



## APPENDIX A: Weight Management Assessment Data Collection Sheet

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ in.      WEIGHT: \_\_\_\_\_ lbs.      AGE: \_\_\_\_\_

PHYSICIANS NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

### PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)

	Questions	Yes	No
1	Has your doctor ever said that you have a heart condition and that you should only perform physical activity recommended by a doctor?		
2	Do you feel pain in your chest when you perform physical activity?		
3	In the past month, have you had chest pain when you were not performing any physical activity?		
4	Do you lose your balance because of dizziness or do you ever lose consciousness?		
5	Do you have a bone or joint problem that could be made worse by a change in your physical activity?		
6	Is your doctor currently prescribing any medication for your blood pressure or for a heart condition?		
7	Do you know of <u>any</u> other reason why you should not engage in physical activity?		

*If you have answered "Yes" to one or more of the above questions, consult your physician before engaging in physical activity. Tell your physician which questions you answered "Yes" to. After a medical evaluation, seek advice from your physician on what type of activity is suitable for your current condition.*



## GENERAL & MEDICAL QUESTIONNAIRE

	Occupational Questions	Yes	No
<b>1</b>	What is your current occupation? _____		
<b>2</b>	Does your occupation require extended periods of sitting?		
<b>3</b>	Does your occupation require extended periods of repetitive movements? (If yes, please explain.) _____		
<b>4</b>	Does your occupation require you to wear shoes with a heel (dress shoes)?		
<b>5</b>	Does your occupation cause you anxiety (mental stress)?		
	<b>Recreational Questions</b>	<b>Yes</b>	<b>No</b>
<b>6</b>	Do you partake in any recreational activities (golf, tennis, skiing, etc.)? (If yes, please explain.) _____ _____		
<b>7</b>	Do you have any hobbies (reading, gardening, working on cars, exploring the Internet, etc.)? (If yes, please explain.) _____ _____		
	<b>Medical Questions</b>	<b>Yes</b>	<b>No</b>
<b>8</b>	Have you ever had any pain or injuries (ankle, knee, hip, back, shoulder, etc.)? (If yes, please explain.) _____ _____		
<b>9</b>	Have you ever had any surgeries? (If yes, please explain.) _____ _____		
<b>10</b>	Has a medical doctor ever diagnosed you with a chronic disease, such as coronary heart disease, coronary artery disease, hypertension (high blood pressure), high cholesterol or diabetes? (If yes, please explain.) _____ _____		
<b>11</b>	Are you currently taking any medication? (If yes, please list.) _____ _____ _____		