Patient Education & Wellness Program
of Community Care Physicians, P.C.

COMMUNITY CARE PHYSICIANS, P.C.

What is Medically Supervised Weight Management?

- We integrate medical evaluation, nutritional counseling, exercise guidance and behavior modification to help you reach your goals.

What should I expect in the beginning of my program?

- You will meet with one of our providers and members of our staff for an extended initial appointment. You will receive a comprehensive evaluation that will include review of your medical, nutrition, exercise, and behavioral history.
- Lab work, and/or testing may be recommended.

How often do I come in?

Depending on your needs, we will see you approximately every 4 weeks, but you can be seen more frequently if desired.

How long will I be in the program?

- There is no limitation in how long you are able to work with us.
- Once you reach your desired goal, we recommend continuing in our maintenance program to help ensure you are sustaining the changes you wanted to make. During this time, you are generally seen less frequently.

Will my insurance cover this?

- Weight Management is covered by **most** major insurance carriers.
- Certain Insurance plans may have restrictions regarding the number of visits that they allow and/or diagnosis used.
- If not covered by your insurance, we do offer out of pocket options.

PRE-VISIT QUESTIONNAIRE

We ask that this questionnaire be completed and returned to the office at least 1 week prior to your initial appointment.

Thank you for your interest in the **Patient Education and Wellness Program**, medically supervised weight management at Community Care Physicians, P.C. In order for us to prepare for your appointment, we require that you complete this pre-visit questionnaire. **Please answer all questions completely and honestly.**

If your primary care physician is not part of Community Care, we require records from your primary care provider. We need to receive these records at least 1 week prior to your initial appointment. If we are missing your questionnaire or your primary care records, you may be contacted to reschedule your appointment.

Remember to bring your ID (driver's license) and your insurance card (or a copy of your digital insurance card).

Exercise clothing is not needed as you will not be exercising during your appointments.

Please return this form to:

Patient Education and Wellness Program
501 New Karner Rd., Suite 1A
Albany, NY 12205
PHONE: (518) 713-5347
FAX: (518) 713-5359

Your Name: _____ DOB:_____ Gender: M F

Phone #: _____

Date of Initial Appointment: _____ Provider: _____

Primary Care Physician: _____

Specialists: _____

Name: _____ MRN:_____

PLEASE LIST ANY MEDICATIONS AND OR SUPPLEMENTS THAT YOU ARE TAKING AND DOSAGE:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

PLEASE LIST ANY DRUG ALLERGIES

_____ _____ _____

_____ _____ _____

FOR FEMALE PATIENTS:

DO YOU USE A FORM OF BIRTH CONTROL? (CIRCLE) YES NO

IF YES, WHAT DO YOU USE? _____

MENSTRUAL CYCLE: (CIRCLE) REGULAR , IRREGULAR

ARE YOU: (CIRCLE ANY THAT MAY APPLY) TRYING TO CONCEIVE , MENOPAUSAL , PERI-MENOPAUSAL

MEDICAL HISTORY: (PLEASE MARK ALL THAT APPLY)

- ☐ **High Blood Pressure**
- ☐ **High Cholesterol**
- ☐ **Heart Problems** -Heart Attack, Coronary Disease, Valve Problems , Congestive Heart Failure, Cardiomyopathy, Heart murmur, other: _____
- ☐ **Cerebrovascular Disease**- Stroke, Mini-Stroke, Carotid Artery Disease, other: _____
- ☐ **Peripheral Vascular Disease**
- ☐ **Lung Problems** - COPD, Asthma, pulmonary hypertension, interstitial lung disease, restrictive lung disease, other: _____
- ☐ **Sleep Problems**- Insomnia, Snoring, Sleep Apnea, CPAP, other: _____
- ☐ **Diabetes**
- ☐ **Thyroid Problems** - under or over active thyroid, thyroiditis, thyroid nodule, thyroid removed, other: _____
- ☐ **Kidney Disease** - kidney failure, protein in urine, nephritis, polycystic kidneys, other: _____
- ☐ **Kidney Stones**
- ☐ **Liver Disease** -Hepatitis, Fatty Liver, Cirrhosis, other: _____
- ☐ **Gout**
- ☐ **Gallstones**
- ☐ **GYN Problems** -Polycystic Ovarian Syndrome , Irregular Menses, other: _____
- ☐ **Infertility**
- ☐ **Osteoarthritis** -Back, Neck, Hips, Knees, Feet, other: _____
- ☐ **Rheumatologic Disorder** -Rheumatoid Arthritis, Lupus, Sarcoidosis, Fibromyalgia, other: _____
- ☐ **Mood Disorder** - Anxiety, Depression, Stress, Bipolar Disorder, other _____
- ☐ **Cancer –** type:_____
- ☐ **Eating Disorder** - Anorexia, Bulimia, Binge Eating, Night Eating, other:_____
- ☐ **Neurological Disorder** -Seizures, Migraine, Neuropathy, RSD, other:_____
- ☐ **Gastrointestinal Problems-** Irritable Bowel, Inflammatory Bowel, Colitis, Diverticulitis, Celiac Disease, Reflux, Constipation, other: _____
- ☐ **Addiction –** type: _____
- ☐ **Other:**_____

FOR PATIENTS COMING FOR WEIGHT LOSS

WHAT IS YOUR MOTIVATION TO LOSE WEIGHT?

- ☐ Health
- ☐ Appearance
- ☐ Reduce Medications
- ☐ Improve Mobility/ Exercise Tolerance
- ☐ Other:_____

WHAT IS THE MOST YOU HAVE EVER WEIGHED? _____AT WHAT AGE? _____

WERE YOU OVERWEIGHT OR OBESE AS AN ADOLESCENT/TEENAGER? (CIRCLE) YES NO

HAVE YOU GAINED WEIGHT IN THE PAST YEAR? (CIRCLE) YES NO

- ☐ If yes, how much weight have you gained? _____
- ☐ If yes, have you had any major life changes in the past year?

_____

Name: _____ MRN:_____

WHAT IS YOUR PERSONAL GOAL WEIGHT? _____

WHAT DIETS HAVE BEEN MOST SUCCESSFUL FOR YOUR IN THE PAST AND WHY?

_____

_____

WHY HAVE PREVIOUS DIETS FAILED?

_____

_____

HAVE YOU HAD ANY SURGICAL BARIATRIC PROCEDURES? (CIRCLE) YES NO

- ☐ If yes, explain: _____

HAVE YOU EVER TAKEN OVER THE COUNTER SUPPLEMENTS FOR WEIGHT LOSS? (CIRCLE) YES NO

- ☐ If yes, what supplement _____

HAVE YOU EVER TAKEN ANY PRESCRIPTION MEDICATIONS FOR WEIGHT LOSS? (CIRCLE) YES NO

- ☐ If yes, what medication (circle) Phentermine, Diethylpropion, Xenical, Phendimetrazine, Meridia, Belviq, Qsymia, Contrave, other: _____
- ☐ Did you lose weight with this medication? (circle) YES NO
- ☐ Did you experience any side effects on this medication? (circle) YES NO
  If yes, please explain: _____

FOOD ALLERGIES/SENSITIVITIES

DO YOU HAVE ANY DIETARY RESTRICTIONS? (CIRCLE) YES NO

- ☐ Avoid Dairy
- ☐ Avoid Beef
- ☐ Avoid Pork
- ☐ Gluten Free
- ☐ Vegetarian
- ☐ Pescaterian (Vegetarian, however will eat fish)
- ☐ Lacto-Ovo Vegetarian (will eat eggs and dairy)
- ☐ Ovo Vegetarian (will eat eggs, no dairy)
- ☐ Lacto Vegetarian (will eat dairy, no eggs
- ☐ Vegan (no foods derived from animals)
- ☐ Other_____

DO YOU HAVE ANY FOOD ALLERGIES? (CIRCLE) YES NO

- ☐ If yes , what food(s) _____
- ☐ What type of reaction do you have? _____
- ☐ Do you have an epi-pen? _____

DO YOU HAVE ANY FOOD SENSITIVITIES? (CIRCLE) YES NO

- ☐ If yes, what food(s)_____
- ☐ What type of reaction do you have? _____

DO YOU HAVE ANY SENSITIVITIES TO GLUTEN, LACTOSE, ARTIFICIAL SWEETENERS? (CIRCLE) YES NO

- ☐ If yes, explain_____

EATING HABITS

HOW MANY TIMES PER WEEK DO YOU EAT AT RESTAURANTS OR TAKE-OUT MEALS? _____

WHAT TYPE OF RESTAURANTS DO YOU FREQUENT? _____

☐ Fast Food ☐ Sit – Down / Chain ☐ Pubs ☐ Deli Fine Dining

DO YOU SKIP MEALS? (CIRCLE) YES NO

DO YOU FREQUENTLY SKIP BREAKFAST? (CIRCLE) YES NO

WHO LIVES WITH YOU? _____

DO YOU HAVE SUPPORT AT HOME TO MAKE LIFESTYLE CHANGES? (CIRCLE) YES NO

WHO PREPARES THE MEALS IN YOUR HOME? _____

WHO DOES THE GROCERY SHOPPING? _____

ARE YOU COMFORTABLE READING FOOD LABELS? (CIRCLE) YES NO

ARE YOU COMFORTABLE MEASURING PORTIONS? (CIRCLE) YES NO

HAVE YOU EVER KEPT A FOOD DIARY? (CIRCLE) YES NO

☐ If yes, ☐ on paper ☐ On computer ☐ On phone app ☐ Other: _____

DO YOU EAT AT A KITCHEN OR DINING ROOM TABLE? (CIRCLE) YES NO

DO YOU WATCH TV WHILE YOU EAT? (CIRCLE) YES NO

DO YOU DRINK SODA? (CIRCLE) YES NO

- ☐ If yes, diet or regular? _____

Name: _____ MRN:_____

☐ How much soda/ day? _____

DO YOU DRINK SWEETENED BEVERAGES (IE. JUICE, ENERGY DRINKS, ICE TEA, LEMONADES)? (CIRCLE) YES NO

☐ If yes, what type and how often_____

DO YOU USE ANY ARTIFICIAL SWEETENERS? (CIRCLE) YES NO

☐ IF YES, WHICH ONES? _____

DO YOU DRINK CAFFEINE? (CIRCLE) YES NO

☐ If yes, what type and how much_____

HOW MUCH WATER DO YOU DRINK DAILY? _____

FOOD DIARY – Typical Day

****** Very important that you complete for your Initial Appointment ******

Breakfast	
Snack	
Lunch	
Snack	
Dinner	
Snack	

DO YOU EAT DESSERTS? (CIRCLE) YES NO

☐ If yes, what type? _____

☐ How often? _____

***Please review attached list of common meal plans we offer and indicate which plans would be of interest to you**

SUBSTANCE USE

DO YOU DRINK ALCOHOL? (CIRCLE) YES NO

☐ If yes, how much and how often? _____

☐ How many beverages per week? _____

DO YOU SMOKE CIGARETTES? (CIRCLE) YES NO

ARE YOU A PREVIOUS SMOKER? (CIRCLE) YES NO

☐ If yes, have you quit smoking in the past 6 months? (CIRCLE) YES NO

DO YOU HAVE ANY HISTORY OF ADDICTION? (CIRCLE) YES NO

☐ If yes, explain (including gambling/ shopping/ alcohol/ substance/ sugar, etc.)

_____

DISORDERED EATING

DO YOU EAT FOR REASONS OTHER THAN HUNGER? (CIRCLE) YES NO

☐ If yes, explain: _____

_____

DO YOU HAVE ANY **CURRENT** DISORDERED EATING? (CIRCLE) YES NO

DO YOU HAVE ANY **PAST** ISSUES WITH DISORDERED EATING? (CIRCLE) YES NO

IF YES TO EITHER CURRENT OR PAST, PLEASE INDICATE:

☐ Anorexia ☐ Binge Eating ☐ Stress Eating ☐ Night Eating

☐ Bulimia ☐ Emotional Eating ☐ Overeating ☐ Other: _____

DO YOU HAVE ANY CRAVINGS? (CIRCLE) YES NO FOR WHAT? _____

MOOD:

DO YOU HAVE A HISTORY OF MOOD DISORDERS? (CIRCLE) YES NO . IF YES, PLEASE INDICATE:

☐ Anxiety ☐ Panic Attacks ☐ Anger ☐ Other:_____

☐ Depression ☐ Bipolar Disorder ☐ Irritability

PLEASE INDICATE YOUR LEVEL OF STRESS ON A SCALE OF 1 TO 10 (0 = NO STRESS, 10 = VERY STRESSED) :_____

SLEEP *If yes to any of these sleep questions, please complete the attached *Sleep Apnea Questionnaire*

*DO YOU HAVE ANY DIFFICULTIES WITH SLEEP? (CIRCLE) YES NO

*DO YOU FEEL TIRED IN THE MORNING? (CIRCLE) YES NO

*DO YOU SNORE? (CIRCLE) YES NO

*DO YOU STOP BREATHING AT NIGHT? (CIRCLE) YES NO

DO YOU WORK A NIGHT SHIFT OR SWING SHIFT? (CIRCLE) YES NO

Name: _____ MRN:_____

HOW MANY HOURS OF SLEEP DO YOU GET? _____ DO YOU HAVE SLEEP APNEA? (CIRCLE) YES NO

HAVE YOU EVER HAD A SLEEP STUDY? (CIRCLE) YES NO DO YOU USE A CPAP OR BIPAP MACHINE? (CIRCLE) YES NO

OCCUPATION

- ☐ Homemaker: _____
- ☐ Student: _____
- ☐ Occupation: _____
- ☐ Retired from : _____
- ☐ On Disability:_____
- ☐ Other: _____

IF YOU ARE EMPLOYED, HOW MANY HOURS PER WEEK DO YOU WORK? _____

DO YOU FEEL THAT YOUR JOB IS STRESSFUL? (CIRCLE) YES NO

EXERCISE and ACTIVITY *Please complete the attached "*PAR-Q & You" Exercise Questionnaire*

PLEASE INDICATE THE LEVEL OF ACTIVITY THAT YOUR JOB REQUIRES:

- ☐ Sedentary
- ☐ Light Activity
- ☐ Moderate Activity
- ☐ Heavy Labor

DO YOU EXERCISE? (CIRCLE) YES NO

- ☐ If yes, how many days per week? _____
- ☐ What do you do for exercise? _____
- ☐ How long have you been exercising regularly? _____

IF YOU EXERCISE, PLEASE INDICATE THE INTENSITY OF YOUR EXERCISE

- ☐ Light (you could sing)
- ☐ Moderate (you can speak in complete sentences)
- ☐ Vigorous (you are only able speak a few words)
- ☐ Intervals of moderate and vigorous

WHAT EXERCISES TO YOU ENJOY? _____

DO YOU HAVE ANY LIMITATIONS TO EXERCISE?

- ☐ Injury
- ☐ Health
- ☐ Time
- ☐ Motivation
- ☐ Access

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: (CHECK ALL THAT APPLY)

- ☐ **HEART DISEASE** (heart attack, bypass surgery, stents, angioplasty, coronary disease, sudden death, cardiomyopathy)
  - Was it at a premature age (women under age 65, men under age 55? (CIRCLE) YES NO
- ☐ **DIABETES**
- ☐ **HYPOTHYROID**
- ☐ **SLEEP APNEA**
- ☐ **WEIGHT PROBLEMS**
- ☐ **CANCER**

HAVE YOU EVER HAD AN EKG? (CIRCLE) YES NO

- ☐ If yes, when and where? _____

HAVE YOU EVER HAD A STRESS TEST? (CIRCLE) YES NO

- ☐ If yes, when and where? _____

HAVE YOU EVER HAD AN ECHOCARDIOGRAM? (CIRCLE) YES NO

- ☐ If yes, when and where? _____

Thank you for taking the time to complete this questionnaire. This information will help us prepare for your initial appointment.

INITIAL VISIT NO SHOW / CANCELLATION POLICY:

INITIAL VISITS CAN UP TO 1 HOUR. DUE TO THE LARGE AMOUNT OF TIME AND LIMITED NUMBER OF THESE VISITS, THERE WILL BE A $100.00 CHARGE FOR PATIENTS THAT DO NOT CALL TO CANCEL OR RESCHEDULE THEIR APPOINTMENTS WITHIN A MINIMUM OF 48 HOURS PRIOR TO THEIR VISITS.

THIS ALLOWS US TIME TO CALL OTHER PATIENTS THAT ARE ON OUR WAITING LIST FOR OUR PROGRAM TO COME IN FOR THEIR INITIAL VISIT.

CONSIDERATION WILL BE GIVEN TO SAME DAY CANCELLATIONS BASED ON WEATHER CONDITIONS.

MANAGEMENT

MRN:_____

COMMUNITY CARE PHYSICIANS, P.C.

WAIVER OF LIABILITY AND INFORMED CONSENT RELEASE

I _____ authorize Community Care Physicians, P.C., Linda Katz, FNP and Rachel Colfer, PA and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that I have alternative treatment options, including but not limited to no treatment at all and weight management programs not supervised by a physician.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions, whatsoever, concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Signature of patient or patient representative

Print name: _____ DOB: _____

Signature: _____

Date: _____

Witness signature

Print name: _____

Signature: _____

Date: _____

Name: _____ MRN:_____

WE Care Meal Plan Options

Take a look at our popular meal plan options and check a couple you think you'd be most interested in

☐ **Paleo Lifestyle**

Vegetable, fruit, egg, turkey, nuts, chicken breast, salmon, nori, pork, halibut, tuna, orange roughy (fish), beef loin, shrimp, cod

Low Carb, Gluten Free, Dairy Free

Macronutrient Composition: 30% CHO, 30% Protein, 40% Fat

☐ **Paleo with Dairy**

Fruit, vegetable, egg, turkey sausage, nuts, chicken breast, pork tenderloin, Greek yogurt, cheese, salmon, coconut milk, coconut water, almond butter, tuna, halibut, orange roughy (fish), dried fruit, steak, tilapia

Macronutrient Composition: 40% CHO, 30% Protein, and 30% Fat

☐ **Low Carb Lifestyle**

Grains, fruits, eggs, milk, Greek yogurt, vegetables, vinegar, veggie burger, whole wheat bread, turkey breast, quinoa, salmon, teriyaki sauce, cottage cheese, nuts, cheese, chicken breast, olive oil, tuna, almond butter, Ezekiel bread, peanut butter, almond milk, seeds, turkey bacon, pork loin, hummus, tilapia, whole wheat pasta, protein powder, whole wheat wrap, brown rice, dry steel cut oats, sandwich thin, whole wheat English muffin, Canadian bacon

Low Carb

Macronutrient Composition: 30% CHO, 30-40% Protein, and 30-40% Fat

☐ **Low Carb Mediterranean**

Cottage Cheese, milk, fruit, peanut butter, lentils, seeds, yogurt, Greek yogurt, shrimp, couscous, beans, dried fruit, tuna, whole wheat bread, eggs, salmon, sweet potatoes, chicken breast, brown rice, wasa crackers, pita, soup, halibut, veggie burger, oats, nuts,

Macronutrient Composition: 30-40% CHO, 30% Protein, and 30-40% Fat

☐ **Low Carb Vegetarian**

Fruit, cottage cheese, soy burgers, vegetables, egg substitute, soy milk, nuts, eggs, tofu burger, hummus, bean chili, cheese, Greek yogurt, sour cream, whole wheat wrap, rice cake, peanut butter, oil & vinegar, seeds, quinoa, brown rice, pita, almond butter

Low Carb

Macronutrient Composition: 40% CHO, 30% Protein, and 30% Fat

☐ **Low Carb No Juice**

Nuts, seeds, vegetables, vegetable juice, fish , pita, fruit, soup , chicken, beef, turkey, fish, pork, eggs, pasta , cottage cheese, cheese, tortilla, multigrain rolls, yogurt, protein bars , lean cuisine , oatmeal

Low Carb

Macronutrient Composition: 40% CHO, 30% Protein, and 30% Fat

Name: _____ MRN:_____

☐ **Low Glycemic Index (Low GI)**

Fruit, vegetables, skim milk, soy milk, cereal, dried fruit, pumpernickel bread, ham , chicken, fish, pork, turkey sausage , yogurt, cheese, whole wheat pasta, nuts, cream cheese, chickpeas , cottage cheese, sponge cake , hummus, pita, canned soup, sweet potatoes, tortilla , salsa, refried beans , sour cream

Low Carb

Macronutrient Composition: 50% CHO, 25% Protein, 25% Fat

☐ **Low Carb American**

Fruit, vegetables, skim milk, eggs, nuts, seeds, chicken, beef, ham, fish, turkey, cheese, cottage cheese, yogurt, pita, tortilla, crackers, chocolate syrup, ice cream, oatmeal w/ brown sugar, canned soup, peanut butter, beans, vegetable juice, hummus

Low Carb

Macronutrient Composition: 40% CHO, 30% Protein, and 30% Fat

☐ **Detox Veggie (14 days)**

Fruit, vegetables, eggs, nuts, seeds, almond milk, tofu, beans, brown rice

***Ovo-Vegetarian – eggs only, Gluten Free, Lactose Free*

Macronutrient Composition: 50% CHO, 20% Protein, and 30% Fat

☐ **Detox with Meat (14 days)**

Fruit, vegetables, almond milk, cream of rice cereal, nuts, seeds, chicken, beef, almond butter, lentils, eggs, brown rice, rice cakes, cereal

*** Mostly Gluten Free, Low Carb, Lactose Free*

Macronutrient Composition: 50% CHO, 25% Protein, and 25% Fat

***Other plans that can be discussed on an individual basis:**

- Ketogenic (High fat, very low carbohydrate)
- Intermittent fasting (eating pattern that cycles between periods of fasting and eating)

Name: _____ MRN:_____

SLEEP APNEA QUESTIONNAIRE

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	YES	NO
Do you often feel tired, fatigued, or sleepy during daytime?	YES	NO
As anyone observed you stop breathing during your sleep?	YES	NO
Do you have or are you being treated for high blood pressure?	YES	NO
BMI more than 35 kg/m2?	YES	NO
Age over 50 years old?	YES	NO
Neck circumference >16 inches (40 cm)?	YES	NO
Gender: Male?	YES	NO
TOTAL SCORE		

High risk of OSA (Obstructive Sleep Apnea): YES 5 – 8

Intermediate Risk of OSA: YES 3 – 4

Low Risk of OSA: YES 0 – 2

*** Do you have family history of Sleep Apnea in a first degree relative (mother, father, sister, brother)? YES NO**

MRN:_____

Physical Activity Readiness
Questionnaire - PAR-Q
(revised 2002)

PAR-Q & YOU

(A Questionnaire for People Aged 15 to 69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

YES	NO		
☐	☐	1.	**Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?**
☐	☐	2.	**Do you feel pain in your chest when you do physical activity?**
☐	☐	3.	**In the past month, have you had chest pain when you were not doing 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 (for example, back, knee or hip) that could be made worse by a change in your physical activity?**
☐	☐	6.	**Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?**
☐	☐	7.	**Do you know of any other reason why you should not do physical activity?**

If you answered YES to one or more questions

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want — as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

NO to all questions

If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:

- start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

DELAY BECOMING MUCH MORE ACTIVE:

- if you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or
- if you are or may be pregnant – talk to your doctor before you start becoming more active.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

Informed Use of the PAR-Q: The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity.

No changes permitted. You are encouraged to photocopy the PAR-Q but only if you use the entire form.

NOTE: If the PAR-Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

NAME _____

SIGNATURE _____ DATE _____

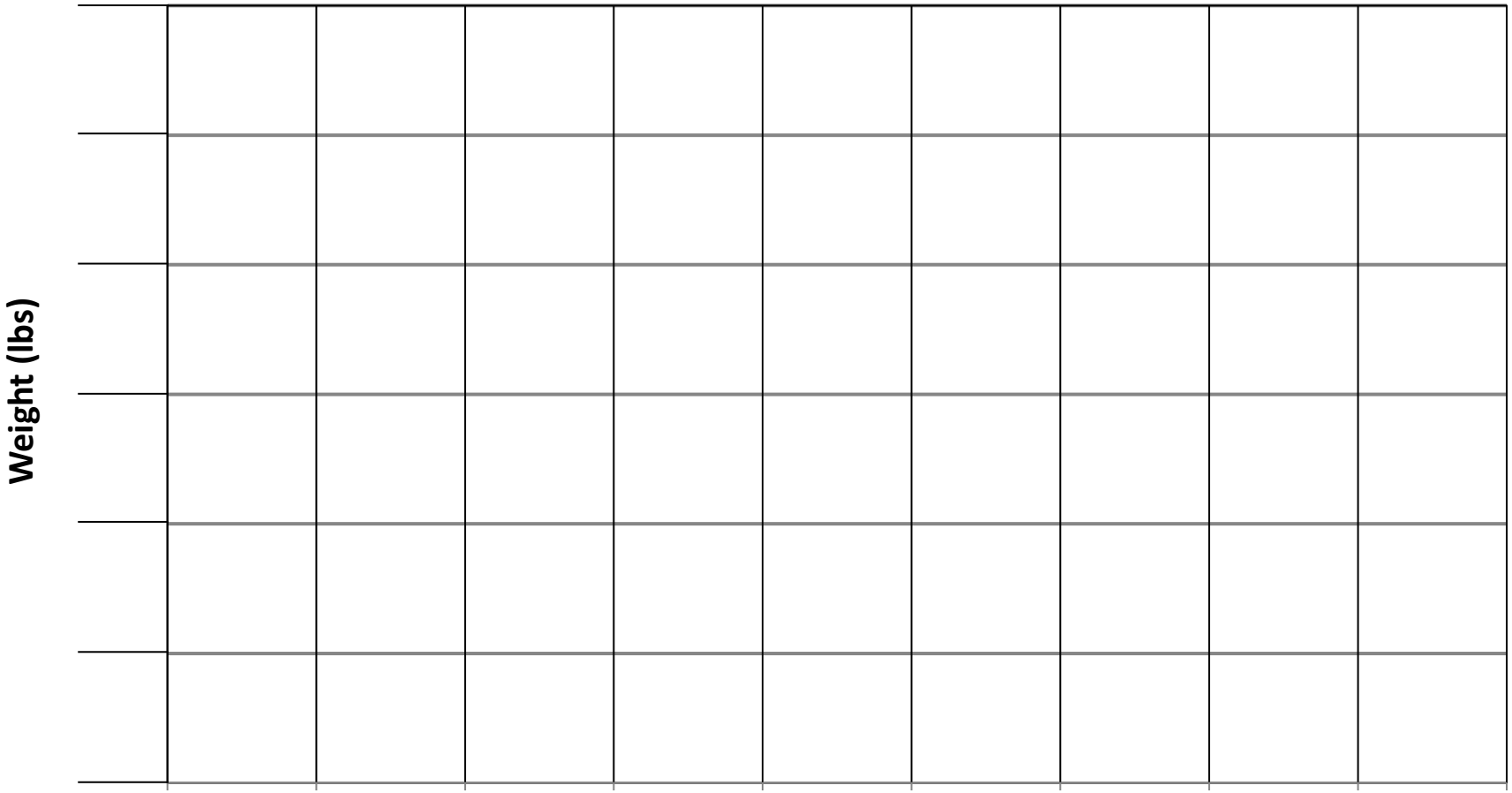
SIGNATURE OF PARENT or GUARDIAN (for participants under the age of majority) _____ WITNESS _____

Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.

CSEP | SCPE

WEIGHT OVER TIME

To the best of your recollection, we would like you to graph out the changes that have occurred in your weight over time. Start from when you were a child and note any pertinent events / health issues that may coincide with changes in your weight (i.e. marriage, divorce, death in the family, etc.). Also indicate any weight loss attempts and the outcome. *** SEE EXAMPLE GRAPH**



EXAMPLE WEIGHT GRAPH