



## PAR-Q

A Questionnaire for People Aged 15 to 69

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 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?
- \_\_\_\_\_ 8. Are you a current patient of Dr. Hopp?

### If you answered YES to one or more of these questions:

Talk with your doctor **BEFORE** you become 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 slow 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'd like to do and follow his/her advice.
- Find out which community programs are safe and helpful for you.

### If you honestly answered NO to all 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.

### Delay becoming more active if:

- You are not feeling well because of temporary illness (such as cold or a fever). Wait until you feel better
- OR**
- You are or may be pregnant. Talk with your doctor before you start becoming active.

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

I agree to waive medical clearance from a physician although I have been advised. Initial:

Signature \_\_\_\_\_ Date \_\_\_\_\_



### HIPAA & Photo & Video Release Privacy Authorization Form

I (please print) \_\_\_\_\_ hereby authorize TLC The Littleton Clinic the authority to disclose information relating to my weight loss experience. This includes, but is not limited to: full name, before and after photo, weight loss story, total weight, video testimonial or any other purpose made known to me.

I acknowledge that by allowing TLC The Littleton Clinic to use my information that I give them the full authority to use that material in marketing campaigns, the Wall of Fame and other testimonials to promote TLC The Littleton Clinic.

I understand that I am granting TLC The Littleton Clinic authority to use my information on an unlimited time frame.

I understand that at any point in time I have the right to withdraw this authorization provided I give written notice to TLC The Littleton Clinic.

I understand that my treatment, sessions, payments, or relationship with anyone associated with TLC The Littleton Clinic will not be affected or conditioned on the signature of this authorization form.

I hereby authorize the release of my weight loss program information through phone calls, voicemails, emails, and text messaging on the contact information provided.

I hereby authorize the release of my complete weight loss experience with TLC The Littleton Clinic. (Full name, before & after photo, weight loss story, total weight loss to date, video testimonial)

I hereby authorize the release of the following from my weight loss experience.

Full Name

First Name

First Name Last Initial

Before Photo

After Photo

Total Weight Lost to Date

Video Testimonial

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date