KIN 6056

Weiler

Case Study

Sheila Williams

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Historical Abstract

Write an abstract of the client and include

- Demographics
- Notable lifestyle factors including habitual physical activity
- Special concerns: physiological
- Special concerns: logistical
- Goals

Risk Assessment

R/O Risk Factors

C.V. Risk Factors (Table 2.2)

- +/- Age
- +/- Family History
- +/- Tobacco
- +/- Sedentary lifestyle
- +/- Obesity
- +/- Blood pressure
- +/- Blood Glucose
- +/- lipids
- Total Risk Factors

Age	-/+ (optional note)
Family History	-/+ (optional note)
Tobacco	-/+ (optional note)
Sedentary Lifestyle	-/+ (optional note)
Obesity	-/+ (optional note)
Blood Pressure	-/+ (optional note)
Glucose Metabolism	-/+ (optional note)
Lipids	-/+ (optional note)
Total RFs	# RF #+ RFs #-RFs

Risk Values

- Age
- Family History
- Tobacco
- Sedentary lifestyle
- Obesity
- Blood pressure
- Blood Glucose
- Lipids

Risk Grading

- Low/Moderate/high risk
- Physician clearance/supervision
-

Precautions

Fitness Assessment

Fitness Testing

Address all testing – consider additional testing (consider tabular presentation)

- Testing interpretation for all components of Health-Related Fitness
    - Flexibility
    - Muscular Endurance
    - Muscular Strength
    - Body Composition
    - Cardiovascular Fitness

Fitness Assessment:

- Assessment of Fitness Status for all components of Health Related Fitness
    - Flexibility
    - Muscular Endurance
    - Muscular Strength
    - Body Composition
    - Cardiovascular Fitness

Summation of Assessment (consider tabular)

Plan:

- Plan
    - Need for additional testing
    - follow-up Abstract
    - Fitness status
    - Goals

Exercise Prescription

ExRx Abstract

ExRx:

	Warm-up	Cool-down
Frequency		
Intensity		
Time		
Type		
Notes:		

	Cardiovascular Fitness	Muscular Strength	Muscular Endurance	Flexibility	Body Composition
Frequency:					
Intensity:					
Time:					
Type:					
Volume:					
Progression:					
Notes:					

- ExRx
  - Warm-up/Cool Down RX and notes
  - F.I.T.T.V for each component of health-related fitness
    - Progression
    - Notes
  - ExRx for special concerns
  - ExRx for clients goals

Exercise Supervision

- Supervision (acute and chronic)
    - Records
    - Tools
    - Progression

ExRx Summary & Plan

- ExRx Summary and Plan

Appendices

Appendix A: History & Demographics

Clinical Exercise & Tennis Center

Patient: Williams, Sheila Intake transcribed by: SKW

Kinesiologist: Hi Sheila, can you tell me a little about yourself?

Sheila: Sure! I'm 67 and retired now—I used to be the Parks and Recreation Director here in Mesa. These days, I'm really active in my community. I play pickleball about three or four times a week, and I regularly place in the top three in my age group tournaments. I also do water aerobics three mornings a week and go to a bridge club every week. I try to lift weights with my legs a couple times a week too—though I'll admit, I worry a bit that it might make me look bulky.

Kinesiologist: That's impressive. You're very active. Dr. Borg referred you to us, I think primarily because of your diagnosis of Osteoporosis. Is that what motivates you?

Sheila: Honestly, I've just been feeling like I'm "getting older," and I really want to stay ahead of things. My mom's health has declined quite a bit—she's weak, needs assistance for everything, and has had some serious falls. We're even considering assisted living for her. I don't want to end up in that situation myself, so I figured it was time to start working with someone like you.

Kinesiologist: That makes a lot of sense. How's that been for you, being her caregiver?

Sheila: It's hard. I'm the primary caregiver and I help with all her daily tasks, but I also share the responsibilities with my siblings and a home healthcare team who comes every day. It's definitely stressful, but I want to do what I can for her. I worry sometimes for our safety when I'm helping her in the bathroom or moving from her bed to the living room.

Kinesiologist: Well we can help you with safe lifting techniques and make sure you have the strength and reserve to do that work. Do you have any health issues of your own we should talk through?

Sheila: I've been pretty healthy overall. The main thing is osteoarthritis—it acts up in my hands and knees. I also had a spinal fracture at L4 back in 2021, related to osteoporosis. But Dr. Borg knows how active I've been and said he would send you information in my referral. We did a lot

of fitness testing and Dr. Borg wants me to exercise more vigorously but safely and he wants me resistance training. I'm not sure why I need to do more than I am doing.

Kinesiologist: I think there are things we can add to your routine to help you maintain your bone health and work more safely with your mom. Also Pickleball is a great way to stay in shape but we want to make sure you stay safe. Any family history of arthritis, osteoporosis or other serious illness?

Sheila: No diabetes or cancer in the family, thankfully. My dad died of a heart attack at 75, and my sister who's 61 has asthma. My oldest sister unfortunately had a fall and passed away at 74. That scares me for my mom and a little bit for myself. I don't want to fall and I don't want my last year of life to be like my sister's. I have two other siblings without any major health issues. We're close and they help me care for my mom.

Kinesiologist: And what's your main goal for working together?

Sheila: I want to keep my independence and stay healthy for the long haul. Longevity runs in my family, and I want to make the most of that, starting with staying strong, avoiding falls, and keeping up the lifestyle I enjoy.

Kinesiologist: Well I have reviewed your notes and testing results from Dr. Borg and I think you have done a great job educating me about yourself. I have a detailed exercise program which I would like to discuss and show to you if you think you would like to get started? We are going to build off of the great physical activities you already do and add some exercises based on your information and Dr. Borg's referral. We will keep you and Dr. Borg informed of your progress and you and I will stay in constant contact throughout your exercises.

KIN 6056: Clinical ExRx: Sheila Williams

Sheila Williams is a pleasant 67-year-old women who is a retired parks and recreation director in Mesa, Arizona. Ms. Williams is coming to see you because she feels as though she is “getting older” and wants to avoid the conditions her mother is suffering currently. Her mother is weak, lives with Ms. Williams with assistance, has injured herself falling and may soon have to move to an assisted living facility.

Ms. Williams is concerned and stressed as the primary care giver of her mother. She helps her mother with all activities of daily living sharing those duties with other siblings and professional home health care which visits daily.

Ms. Williams herself is an avid pickleball player, and regularly places in the top 3 in her “55 and over” community tournaments. She is active in her community and attends water aerobics 3 mornings per week and plays in a bridge club weekly. She plays pickleball 3 or 4 times per week. She lifts weights with her legs 2-3xs/week in the community fitness center. She is worried lifting will make her look “bulky.”

Ms. Williams is very independent and wants to remain that way for the rest of her life. Longevity runs in her family. She is relatively free of illness with the exception of Osteoarthritis which particularly bothers her in her hands and knees. She had a osteoporotic fracture of her spine at L4 in 2021.

Ms. Williams’ doctor would like her to work with you to establish a regular exercise regimen. Many fitness tests have been performed and her doctor has released her for vigorous exercise with an emphasis on resistance training.

Ms. Williams has no family history of diabetes, or cancer. Her father had a fatal heart attack at 75 years old. Her sister is living with asthma and is 61 years old. Her oldest sister suffered an injurious fall and died at age 74. She has two other siblings with no remarkable health history.

Appendix B: **Testing**

AHI Fitness Referral Packet

Dr: Gunner Borg Patient: Sheila Williams DOB: 03/08/1958

Medications:

Medication	Dose	Frequency	Reason:
Ibuprofen	500 mg	t.i.d.	Arthritis
Vitamin D3	600 IU	qd	
Fosamax		1/week	Osteoporosis
Calcium	600 mg	qd	

Lifestyle:

Smoker: No **Drinks/week**: No

Do you have any reason that you could not exercise or concerns when you exercise?
Arthritis hands and knees

Goals: Doctor wants me to weight train, maintain health & independence, help my mother, avoid heart disease like my father.

FITNESS TESTING:

Body Composition/Anthropometry:

DEXA Scan Ordered: Yes✓ No__ Resting Metabolic Ordered: Yes__ No✓

Height: 70” Weight: 130lbs Are you happy with your weight? No

Chest:	Abdomen:	Waist:	Buttocks/hip:	Waist/Hip:
30”	26”	24”	34”	

DEXA: 2/26/2026

Total Body Mass:	130 lbs.	100%	Percentile:	Qualitative:
Lean Body Mass:	104 lbs.	70%		
Fat Mass:	32.5 lbs.	25%		

Muscular Endurance:

Crunches: - Notes: *No test - Hx of Osteoporosis*

Push ups: 19 Notes: *From knees, stopped: straining, poor form x 2*

YMCA BP: 24 Notes: *Very good form*

Strength:

Strength Test:	Absolute Strength:	Relative Strength:	Percentile:	Qualitative:	Notes
Bench Press:	35 lbs.				
Leg Press:	105 lbs.				
Grip Strength:	23kg				Both hands x2 – high score
Vertical Jump:	-----				No test – Osteoporosis

Senior Fitness Testing:

Test	Score	Interpretation
Chair Stands:	16	
Arm Curls:	18	
6min Walk:	645	
2-Min Step	100	
8-ft Up & Go:	4.6	

Flexibility:

S&R: 13” Score:_____ Notes:_____

Test	R: Score L:		Interpretation:
Hip Extension	17°		
Hip Flexion	131°		
Knee Flexion	R:126°	L:130°	
Knee Extension	R:1°	L:1°	
Ankle Dorsiflexion	R:11° °	L:10	
Ankle Plantarflexion	R:55°	L:55°	
Shoulder Flexion	R:170°	L:166°	
Elbow Flexion	R:150°	L:148°	
Elbow Extension	R:5°	L:4°	
Elbow Pronation	R:87°	L:86°	
Elbow Supination:	R:87°	L:86°	

Cardiovascular Fitness:

GXT ordered: Yes: ✓ No:__ ECG Yes:✓ No:__ VO_2: Measured __ Predicted✓

$METs_{max:}$ 7.0 METs_____ VO_2_____

HR_{max} 155 bpm_____ BP_{max}: 164/78 mmHg RPP:25,420

CV Fitness Assessment _____

DEXA (dual-energy X-ray absorptiometry) Report

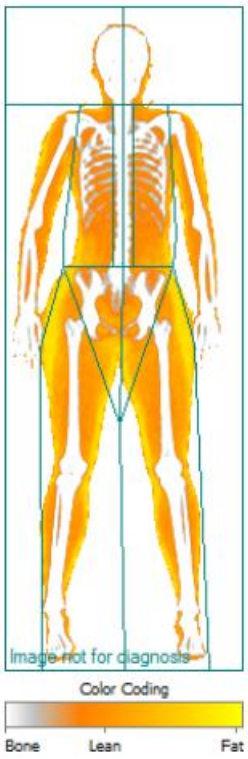
Report Date: 2/26/2026 Report#: 123-456

Name:	**Gender:**	**Birth Date:**
Sheila Williams	Female	03/08/1958
Height (inches):	**Weight (lbs.):**	**Body Mass Index (kg/m^2):**
70”	130	

Body Composition Results					
Measure Date:	**Total Body Mass (lbs.):**	**Total Fat Mass (lbs.):**	**Body Fat Percentage:**	**Total Lean Mass (lbs.):**	**Total Bone Mass (lbs.):**
2/1/2024	132	35.6	27%	89.8	7.3
2/26/2026	130	32.5	25%	90.4	7.2

Normative Data: **American Council on Exercise Recommendations**

Description	Men:	Women:
Essential Fat:	2% - 5%	10% – 13%
Healthy Range	6% – 24%	14% - 31%
Increase Risk	≥25%	≥32%



Regional Distribution: Body composition of 5 regions which may overlap. See Appendix A region descriptions, information and references

Region	Total Mass (lbs.)	Regional Fat %	Fat Mass (lbs.)	Lean Mass (lbs.)	Bone Mass (lbs.)
Arms:					
Legs:					
Trunk:					
Android:					
Gynoid					

Graded Cardiovascular Exercise Test

Name: Sheila Williams	**DOB/Age:** 67	**Date:** 05/26/2026

Pertinent Medications: Patient took medication this morning.

Medication	**Dosage**	**Reason**
Ibuprofin	500mg – t.i.d.	Arthritis
Fosamax	1x/week	Osteoporosis
Calcium	600mg – qd	Osteoporosis
Vitamin D3	600 IU – qd	Osteoporosis

Resting Vitals:

RHR: 82 bpm regular	**RBP: L:**104/78 **R:** 102/78 mmHg

Habitual Exercise:

Type:	**Frequency**	**Intensity**	**Duration**
Pickleball	3-4xs/week	Moderate	60 - 90 minutes
Water Aerobics	3x/week	Moderate	45 minutes
Resistance Training	2-3xs/week	Vigorous	20 minutes

Special Considerations:	None
PMHR:	153 bpm
85% PMHR:	130 bpm

Protocol:	Balke

Results:

Total Exercise Time	**MHR:**	**METs (last completed stage with steady-state HR)**
14'08"	155 bpm	7.2 METs
Rate Pressure Product	**Max Test Y/N**	**Predicted VO_2**
25,420	Maximal	
Reasons for Stopping:	Fatigue, Patient request.	
Remarks:	Maximal effort, Rare PVC, no ischemia, proper hemodynamic response	

Graded Cardiovascular Exercise Test

Name: Sheila Williams	**DOB/Age:** 67	**Date:** 05/26/2026

GXT: Balke

Speed: Men: 3.3mph **Women:** 3.0mph **Stage duration:** 1 minute

Stage:	METs:	HR (bpm):	RPE	BP	Notes/Sx:
1	1.9	90	10	112/82	no symptoms
2	2.3	96	11	118/80	
3	2.7	100	11	122/80	Single PVC, no symptoms, no ischemic changes
4	3.1	105	12	132/80	no arrythmia, no symptoms, no ischemic changes
5	3.5	110	14	140/84	No arrythmia, no ischemic changes, fatigue
6	3.9	116	15	150/80	No arrythmia, no ischemic changes, increased fatigue
7	4.3	120	15	152/80	
8	4.6	125	15	162/80	
9	5.0	130	16	160/76	
10	5.4	136	17	162/78	
11	5.8	140	17	160/78	
12	6.2	145	18	162/80	
13	6.6	153	18	164/78	No arrythmia, no ischemic changes, increased fatigue – pt “can’t go much longer.”
14	7.0	155	19	164/78	Test terminated: MHR reached, inability to keep up with belt, request @ 20 seconds
15	7.4	--	--	--	
					RECOVERY: Supine
R1		132			1-minute supine recovery: 2 PVCs, no ST Segment depression, BP: 160/86, no symptoms
R2		122			2-minute recovery: no arrythmia, no symptoms, no ischemic changes
R3		116			3-minute recovery: no arrythmia, no symptoms, no ischemic changes
R4		102			4-minute recovery: no arrythmia, no symptoms, no ischemic changes

Notes: Test terminated at MHR, pt request – inability to keep pace with belt.

AHI Fitness Laboratory

Report Status: FINAL Sheila Williams **DOB:** 03/08/1958 **Fasting:** Y
Collected: 5/25/2026
Reported: 5/26/2026

Glucose Metabolism:

Glucose:	74 mg/dl	70-99 mg/dl
Hemoglobin A1c	5.1%	≤5.6

Lipid Panel:

Cholesterol:	180	<199 mg/dl
Cholesterol/HDL	3.6	<4.9
HDL Cholesterol	50	>40 mg/dl
LDL Cholesterol	96	≤99 mg/dl
Triglyceride	92	≤149 mg/dl

AHA/ACSM HEALTH/FITNESS FACILITY PREPARTICIPATON SCREENING QUESTIONAIRE

Name: Sheila Williams Date of birth: 7/8/1958 Age: 67
Pulse: 82 bpm, Regular Blood Pressure: 102/78 mmHg 5/26/2026

Assess YOUR health status by marking all true statements	
Yes/No	**Medications:**
	You take prescription medications for your heart.
Yes	You take other prescription medications
	Symptoms:
	You experience chest discomfort with exertion
	You experience unreasonable breathlessness
	You experience dizziness, fainting, blackouts
	History:
	Heart Attack
	Heart Surgery
	Cardiac Catheterization with angioplasty/stent placement (PTCA)
	Heart Valve Disease
	Heart Failure
	Pacemaker/implantable cardiac defibrillator
	Heart Transplant
	Congenital Heart Disease
	Other notable health issues:
	You have diabetes
	You have asthma or lung disease (example: COPD)
	You have burning/cramping sensation in your lower legs walking short distances
Yes	You have musculoskeletal problems that limit your physical activity
Yes	You have concerns about the safety of exercise
	You are pregnant
	Cardiovascular Risk Factors:
	You are a man over age 45
Yes	You are a woman older than 55 years, have had a hysterectomy or are postmenopausal.
	You smoke of have quit smoking within the previous 6 months
	Your blood pressure is greater than 140/90 mmHg
	You do not know your blood pressure
	You take medication for your blood pressure
	Your blood cholesterol is greater than 200 mg/dl
x	You do not know your cholesterol level
	You have a close blood relative who had a heart attack or heart surgery before age 55 (father/brother) or 65 (mother/sister)
	You are physically inactive (i.e. your physically active on at least 3 days per week
Yes	You are more than 20 pounds overweight.

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The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

GENERAL HEALTH QUESTIONS

Please read the 7 questions below carefully and answer each one honestly: check YES or NO.	YES	NO
1) Has your doctor ever said that you have a heart condition ☐ **OR** high blood pressure ☐?	☐	✓
2) Do you feel pain in your chest at rest, during your daily activities of living, **OR** when you do physical activity?	☐	✓
3) Do you lose balance because of dizziness **OR** have you lost consciousness in the last 12 months? Please answer **NO** if your dizziness was associated with over-breathing (including during vigorous exercise).	☐	✓
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? **PLEASE LIST CONDITION(S) HERE:** Osteoporosis	✓	☐
5) Are you currently taking prescribed medications for a chronic medical condition? **PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:** Fosamax, Calcium, Vit D3, Ibuprofin	✓	☐
6) Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer **NO** if you had a problem in the past, but it **does not limit your current ability** to be physically active. **PLEASE LIST CONDITION(S) HERE:** Spine Fracture 2021	✓	☐
7) Has your doctor ever said that you should only do medically supervised physical activity?	✓	☐

☑ **If you answered NO to all of the questions above, you are cleared for physical activity.**
Please sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.

- Start becoming much more physically active – start slowly and build up gradually.
- Follow Global Physical Activity Guidelines for your age (https://www.who.int/publications/i/item/9789240015128).
- You may take part in a health and fitness appraisal.
- If you are over the age of 45 yr and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
- If you have any further questions, contact a qualified exercise professional.

PARTICIPANT DECLARATION
If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for its records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME Sheila Williams DATE 5/25/2026

SIGNATURE _____ WITNESS Venessa Williams

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.

Delay becoming more active if:

- You are currently experiencing a temporary illness, such as a cold or fever. It is best to wait until you feel better.
- You are pregnant. In this case, talk with your health care practitioner, physician, qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes. Answer the questions on Pages 2 and 3 of this document and/or talk to your health care practitioner, physician, or qualified exercise professional before proceeding with any physical activity program.

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FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)

1. Do you have Arthritis, Osteoporosis, or Back Problems?

If the above condition(s) is/are present, answer questions 1a-1c — If **NO** ☐ go to question 2

1a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ✓	NO ☐
1b.	Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)?	YES ✓	NO ☐
1c.	Have you had steroid injections or taken steroid tablets regularly for more than 3 months?	YES ☐	NO ✓

2. Do you currently have Cancer of any kind?

If the above condition(s) is/are present, answer questions 2a-2b — If **NO** ✓ go to question 3

2a.	Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck?	YES ☐	NO ☐
2b.	Are you currently receiving cancer therapy (such as chemotheraphy or radiotherapy)?	YES ☐	NO ☐

3. Do you have a Heart or Cardiovascular Condition? This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm

If the above condition(s) is/are present, answer questions 3a-3d — If **NO** ✓ go to question 4

3a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐	NO ☐
3b.	Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction)	YES ☐	NO ☐
3c.	Do you have chronic heart failure?	YES ☐	NO ☐
3d.	Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?	YES ☐	NO ☐

4. Do you currently have High Blood Pressure?

If the above condition(s) is/are present, answer questions 4a-4b — If **NO** ✓ go to question 5

4a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐	NO ☐
4b.	Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer **YES** if you do not know your resting blood pressure)	YES ☐	NO ☐

5. Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes

If the above condition(s) is/are present, answer questions 5a-5e — If **NO** ✓ go to question 6

5a.	Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies?	YES ☐	NO ☐
5b.	Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness.	YES ☐	NO ☐
5c.	Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, **OR** the sensation in your toes and feet?	YES ☐	NO ☐
5d.	Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)?	YES ☐	NO ☐
5e.	Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future?	YES ☐	NO ☐

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6. **Do you have any Mental Health Problems or Learning Difficulties?** This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome

If the above condition(s) is/are present, answer questions 6a-6b — If **NO** ☑ go to question 7

6a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
6b.	Do you have Down Syndrome **AND** back problems affecting nerves or muscles?	YES ☐ NO ☐

7. **Do you have a Respiratory Disease?** *This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure*

If the above condition(s) is/are present, answer questions 7a-7d — If **NO** ☑ go to question 8

7a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
7b.	Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?	YES ☐ NO ☐
7c.	If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?	YES ☐ NO ☐
7d.	Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?	YES ☐ NO ☐

8. **Do you have a Spinal Cord Injury?** *This includes Tetraplegia and Paraplegia*

If the above condition(s) is/are present, answer questions 8a-8c — If **NO** ☑ go to question 9

8a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
8b.	Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?	YES ☐ NO ☐
8c.	Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?	YES ☐ NO ☐

9. **Have you had a Stroke?** *This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event*

If the above condition(s) is/are present, answer questions 9a-9c — If **NO** ☑ go to question 10

9a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
9b.	Do you have any impairment in walking or mobility?	YES ☐ NO ☐
9c.	Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?	YES ☐ NO ☐

10. **Do you have any other medical condition not listed above or do you have two or more medical conditions?**

If you have other medical conditions, answer questions 10a-10c — If **NO** ☑ read the Page 4 recommendations

10a.	Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months **OR** have you had a diagnosed concussion within the last 12 months?	YES ☐ NO ☐
10b.	Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?	YES ☐ NO ☐
10c.	Do you currently live with two or more medical conditions?	YES ☐ NO ☐

PLEASE LIST YOUR MEDICAL CONDITION(S) AND ANY RELATED MEDICATIONS HERE:

GO to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.

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If you answered NO to all of the FOLLOW-UP questions (pgs. 2-3) about your medical condition, you are ready to become more physically active - sign the PARTICIPANT DECLARATION below:

- It is advised that you consult a qualified exercise professional to help you develop a safe and effective physical activity plan to meet your health needs.
- You are encouraged to start slowly and build up gradually - 20 to 60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
- As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
- If you are over the age of 45 yr and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

If you answered **YES** to **one or more of the follow-up questions** about your medical condition:

You should seek further information before becoming more physically active or engaging in a fitness appraisal. You should complete the specially designed online screening and exercise recommendations program - the **ePARmed-X+ at www.eparmedx.com** and/or visit a qualified exercise professional to work through the ePARmed-X+ and for further information.

Delay becoming more active if:

- You are currently experiencing a temporary illness, such as a cold or fever. It is best to wait until you feel better.
- You are pregnant. In this case, talk to your health care practitioner, physician, qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes. Talk to your health care practitioner, physician, or qualified exercise professional before continuing with any physical activity program.

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The authors, the PAR-Q+ Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q+ or ePARmed-X+. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

PARTICIPANT DECLARATION

- All persons who have completed the PAR-Q+ please read and sign the declaration below.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME Sheila Williams DATE 5/25/2026

SIGNATURE _____ WITNESS V. Williams

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

For more information, please contact
www.eparmedx.com
Email: eparmedx@gmail.com

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Appendix C: Informed consent

Appendix D: Emergency