Community Health Team

Physical Activity Screening Form

Name______________________________ Date of Birth: _________________
Phone Number______________________ Health Card #___________________________________
Program Name, Start Date & Location____

Note: Screening form must be signed and submitted 5 business days before your program start date. Please read and answer the following questions honestly. Check **YES** or **NO** to each question.

YES ☐ **NO** ☐ 1. Do you regularly exercise at a moderate to vigorous pace for 30 minutes at least 3 days per week? (i.e.: moderate to brisk paced walking, cycling, aerobics, dancing)

YES ☐ **NO** ☐ 2. Have you been diagnosed with diabetes, kidney disease or a heart problem **(heart attack, blockages, valve or heart surgery, angina, stroke, etc)**?

YES ☐ **NO** ☐ 3. Do you have high blood pressure with readings that are often over 160/90?

YES ☐ **NO** ☐ 4. Do you have angina (experience pain, tightness, pressure or discomfort in your chest, arms, back, neck or jaw) **at rest or** with physical activity?

YES ☐ **NO** ☐ 5. Do you have shortness of breath with mild physical activity (walking at your own pace on the level ground) at rest, or when you are lying down?

YES ☐ **NO** ☐ 6. Do you experience dizziness, faintness, or blackouts?

YES ☐ **NO** ☐ 7. Do you have swelling in both feet that is more obvious at night?

YES ☐ **NO** ☐ 8. Have you had more than one fall in the past year?

YES ☐ **NO** ☐ 9. Have you or any close relatives been told you have an aneurysm?

YES ☐ **NO** ☐ 10. Have you ever been told that you have a bicuspid aortic valve?

YES ☐ **NO** ☐ 11. Have you ever been told you have a connective tissue disease?

YES ☐ **NO** ☐ 12. Have you received treatment for cancer in the last 3 months?

YES ☐ **NO** ☐ 13. Do you have osteoporosis?

A Community Health Team Physiotherapist may contact you for more information. Please be advised that you are exercising at your own risk. Should your health status change it is your responsibility to tell the Community Health Team.

Signature____ **Date**__________________________

Please return completed form to your Community Health Team office in person or by using one of the methods listed below:

Scan form and Email:	**Mail:**	**Fax:**
cht@nshealth.ca	Community Health Team 6080 Young St. Suite 105 Young Tower Halifax, NS B3K 5L2	902-455-7910

Office Use Only **Safe to begin Exercise program:** **YES** □ **NO** □ **Screened by:** ____

Comments:____

____

____

*For **Move To Improve Program** only:*

Do you have a chronic condition? ____

Currently how many days per week and how many minutes are you doing moderate to vigorous physical activity:

_____days x _____minutes =_____ total