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: cht@nshealth.ca
Mail: Community Health Team 6080 Young St. Suite 105 Young Tower Halifax, NS B3K 5L2
Fax: 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