



## 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.

**Balance Questions: If you intend to participate in Ready Set Move (Balance and Stretching), please answer questions, 11, 12, 13 ONLY.**

**Please answer YES or NO to the following questions, or leave it blank if you are unsure.**

- 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. Have you ever been told you have a connective tissue disease?
- Yes \_\_\_ No \_\_\_ 7. Do you have swelling in both feet that is more obvious at night?
- Yes \_\_\_ No \_\_\_ 8. Have you received treatment for cancer in the last 3 months?
- 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. Do you experience dizziness, fainting, or blackouts?
- Yes \_\_\_ No \_\_\_ 12. Have you had more than one fall in the past year?
- Yes \_\_\_ No \_\_\_ 13. Do you have osteoporosis?
- Yes \_\_\_ No \_\_\_ 14. Did you have or think you had Covid-19?  
If yes, are you still experiencing symptoms? Yes \_\_\_ No \_\_\_



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Physical Activity Screening Form**

Briefly describe your symptoms: \_\_\_\_\_

15. Is there anything else about your health history that you would like us to know? \_\_\_\_\_

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