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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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:	**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