Community Health Team
Physical Activity Screening Form

Name__________________________ Date of Birth __________________________

Phone __________________________ Health Card # ________________________

Email Address: ____

Program Name ____________________________________

Start Date ____

Location ____

Note: Screening form must be submitted 5 business days before your program start date.

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

Email:
cht@nshealth.ca

Mail:
Community Health Team
6080 Young St. Suite 105 Young Tower
Halifax, NS B3K 5L2

Fax:
902-455-7910

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?

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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** ☐

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.

Name ____ **Date**___________________________

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