nova scotia health authority

Community Health Team

PHYSICAL ACTIVITY SCREENING FORM

Name_____ Phone Number_____
Health Card #_____ Date of birth_____
Program Name_____
Program Start Date & Location_____

Note: Screening form must be signed and submitted no later than 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. Has your doctor ever said that you have a heart condition **and** that you should only do physical activity recommended by a doctor?

YES ☐ **NO** ☐ 2. Do you have angina (feelings of pain, tightness or discomfort in your chest, arms, back, neck or jaw) when you do physical activity **or** when at rest?

YES ☐ **NO** ☐ 3. Do you have shortness of breath with mild physical activity (walking at your own pace on the level ground) **or** at rest?

YES ☐ **NO** ☐ 4. Do you have shortness of breath when lying down?

YES ☐ **NO** ☐ 5. Do you experience dizziness, faintness, or blackouts?

YES ☐ **NO** ☐ 6. Do you ever have swelling in your ankles?

YES ☐ **NO** ☐ 7. Have you had more than one fall in the past year?

YES ☐ **NO** ☐ 8. **For participants with diabetes**: Do you regularly have blood sugars below 4.0 or above 11.0?

9. Have you ever been told that you have **(check all that apply):**

YES ☐ **NO** ☐ A hereditary aneurysm (thoracic, ascending aortic, aortic root)?

YES ☐ **NO** ☐ A first or second degree relative with known hereditary aneurysm or who has died suddenly?

YES ☐ **NO** ☐ A connective tissue disease (ie: Marfans, Ehlers Danlos)?

YES ☐ **NO** ☐ A bicuspid aortic valve or have had an aortic root repair?

YES ☐ **NO** ☐ 10. Do you know of **any other reason** why you should not do physical activity?

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If you answered YES to one or more of the above a community health team member will contact you for clarification and to determine whether you need to see your doctor prior to your participation.

If you answered NO to all questions you can be reasonably sure that you can begin this program, however **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 print this form and sign signature with pen)

Please print off and 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:_____

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