

## **Zoom Virtual Exercise Group Informed Consent/Release and Waiver of Liability Form**

I, the undersigned, do hereby acknowledge my consent to take part in a Zoom virtual exercise class offered by the Centre de santé communautaire de l'Estrie (CSCE). A health promoter will be facilitating the exercise program, while a second health promoter offers online support during the virtual exercise session;

I understand that the health promoters work with volunteers who may also provide support during the sessions.

I understand that I will be provided with advice about physical activity, exercise, and other healthy lifestyle topics;

I understand that I may only participate in the Zoom virtual exercise session if I have attended the Zoom orientation session prior to the virtual exercise class and that I will adhere to the following recommendations:

- That I have confirmed and validated the location where I will be doing the online virtual class (address and apartment/unit number/phone number) and have provided the name and phone number of an emergency contact to the facilitators of the program;
- That I can only participate if I have a camera on my electronic device allowing the CSCE staff to observe me at all times while performing the exercises. In doing so, this will allow the CSCE staff to ensure that I am doing the exercises safely and will allow them to respond appropriately in case of an emergency;
- That my emergency contact is aware that I am taking part in the online virtual exercise program and that the CSCE staff have my most recent emergency contact;
- That I will inform the CSCE staff of my departure should I have to leave the session early.
- That I have a phone in proximity in case of an emergency;
- That I will use a sturdy chair (without wheels);
- That I will wear proper footwear;
- That I will have a water bottle/glass of water near me to stay hydrated;
- That I will be exercising in a space which is free and clear from obstacles which might pose a risk for falls.

I understand that Zoom's virtual platform has limitations compared with in person encounters, for example difficulty for the facilitator to properly observe participants' positioning as they perform their exercises.

I understand that I may ask any questions or request further explanation or information about the procedures at any time before, during, and after the virtual exercise session;

I understand that I am responsible for my wellbeing, and that I may modify and/or refrain from certain exercises, and can stop doing the supervised virtual exercise session at any time, provided I inform the CSCE staff responsible for the session if I choose to leave;

I understand that there are risks involved in the exercise program which could include, but are not limited to the following: episodes of transient lightheadedness, abnormal heart rate and/or blood pressure, chest discomfort, leg cramps, nausea, loss of consciousness, and that I voluntarily and willfully

assume those risks;

I understand my obligation to immediately inform the health promoters responsible for the virtual Zoom session of any pain, discomfort, fatigue, difficulty breathing, discomfort in chest, shoulder, jaw, back, neck or any other health symptoms that I may have during or following the virtual exercise class;

I understand that if I observe, feel, or have any symptoms of undue distress, an abnormal response (chest pain, difficulty breathing), or that I think that I am having a stroke or heart attack, I will call 911 immediately and/or notify and/or allow the CSCE online staff to call 911. I understand that the CSCE staff may choose to call 911 if they perceive that I am in immediate distress and/or danger;

I understand that in the event that I am showing signs of being unwell, the CSCE staff will attempt to reach me by phone, and if needed, may directly call 911 on my behalf as well as notify my emergency contact;

I have understood and completed a health screening [e.g., the Get Active Questionnaire] and/or have gotten physician consent confirming my readiness to participate in the Zoom virtual exercise session to become more physically active.

I agree that by participating in the Zoom virtual exercise session, I do so entirely at my own risk, and I voluntarily and willingly assume all risks of injury, illness, or death.

By replying to this e-mail, I acknowledge that I have carefully read this “ZOOM VIRTUAL EXERCISE GROUP INFORMED CONSENT/RELEASE AND WAIVER OF LIABILITY FORM” and fully understand that it is a release of liability. I agree to release the instructors, the Centre de santé Communautaire de l’Estrie, and all of its directors, officers, employees and agents of and from any and all complaints, claims, demands or causes of action and agree to waive any right that I may otherwise have to bring legal action against any CSCE employee. I understand that if I file a complaint, claim, demand or proceeding of any kind whatsoever in relation to my participation in the Zoom virtual exercise session, this Release and Waiver of Liability may be invoked as an obstacle to any such proceeding.

I have read, understand and agree to the terms expressed in this document.

**Full name :** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



## REGISTRATION FORM

File #: \_\_\_\_\_

Date: \_\_\_\_\_

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Assigned sex at birth:  Male  Female  I prefer not answering

Address: \_\_\_\_\_ City and province: \_\_\_\_\_ Postal code: \_\_\_\_\_

Telephone - Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cellular: \_\_\_\_\_

Preferred contact number:

Email: \_\_\_\_\_  I authorize the CSCE to contact me by email.

Date of birth: \_\_\_\_\_ Preferred language of service:  French  English  
(Day / Month / Year)

OHIP Health card number: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ City: \_\_\_\_\_

Name of spouse: \_\_\_\_\_ Tel.: \_\_\_\_\_  
(other than home)

*or in case of a minor*

Name of parents: \_\_\_\_\_ Tel.: \_\_\_\_\_  
(or guardian) (other than home)

\_\_\_\_\_ Tel.: \_\_\_\_\_  
(other than home)

Contact person in case of emergency (*other than spouse or parents/guardian of a minor*):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Tel.: \_\_\_\_\_

### CLIENT HEALTH INFORMATION

Do you currently have a family physician?  Yes  No

Name of physician: \_\_\_\_\_ Name and location of the clinic: \_\_\_\_\_

Health problems including chronic conditions, surgery, previous hospitalization or other - please specify:

Medication you are currently taking (including vitamins and natural products):

Please attach your pharmacy medication record.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Day / Month / Year)

The CSCE can now interact with you via electronic communication, which includes secure videoconference consultations and emails to convey certain types of information like appointment reminders. If you would like us to communicate with you via these methods, please read and sign the Electronic Communications Consent Form.

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Preferred language of service:  French  English  
(Day / Month / Year)

Personal information collected by the Centre de santé communautaire de l'Estrie (CSCE) is used to help make informed decisions about the programs and services it provides to its target population. The information is used solely for this purpose. The CSCE does not sell, trade or divulge any personal information collected within the framework of the provision of its services. As required by law, personal information policies and procedures are implemented at the CSCE.

**What is your SEXUAL IDENTITY?**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Male                   | <input type="checkbox"/> Female                 | <input type="checkbox"/> Intersex               |
| <input type="checkbox"/> Trans - Female to male | <input type="checkbox"/> Trans - Male to female | <input type="checkbox"/> Two-Spirit             |
| <input type="checkbox"/> Do not know            | <input type="checkbox"/> Prefer not to answer   | <input type="checkbox"/> Other (specify): _____ |

**What is your SEXUAL ORIENTATION?**

- |                                      |   |   |
|--------------------------------------|---|---|
| <input type="checkbox"/> Bisexual    | <input type="checkbox"/> Gay                  | <input type="checkbox"/> Heterosexual           |
| <input type="checkbox"/> Lesbian     | <input type="checkbox"/> Queer                | <input type="checkbox"/> Two-Spirit             |
| <input type="checkbox"/> Do not know | <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> Other (specify): _____ |

**Please indicate your highest EDUCATION LEVEL attained?**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Too young           | <input type="checkbox"/> Primary (grades 1-8)  | <input type="checkbox"/> Secondary or equivalent |
| <input type="checkbox"/> College             | <input type="checkbox"/> University bachelor's | <input type="checkbox"/> University postgraduate |
| <input type="checkbox"/> No formal education | <input type="checkbox"/> Do not know           | <input type="checkbox"/> Other (specify): _____  |

**What is your COMBINED ANNUAL HOUSEHOLD INCOME?**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> 0 - \$14,999        | <input type="checkbox"/> \$30,000 - \$34,999 | <input type="checkbox"/> \$90,000 - \$119,999  | <input type="checkbox"/> Do not know          |
| <input type="checkbox"/> \$15,000 - \$19,999 | <input type="checkbox"/> \$35,000 - \$39,999 | <input type="checkbox"/> \$120,000 - \$149,999 | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> \$20,000 - \$24,999 | <input type="checkbox"/> \$40,000 - \$59,999 | <input type="checkbox"/> \$150,000 or more     |   |
| <input type="checkbox"/> \$25,000 - \$29,999 | <input type="checkbox"/> \$60,000 - \$89,999 |  |   |

How many people are supported by this income in your household? \_\_\_\_\_

**What is your CURRENT HOUSEHOLD COMPOSITION?**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Couple with children            | <input type="checkbox"/> Extended family      | <input type="checkbox"/> Do not know            |
| <input type="checkbox"/> Couple without child            | <input type="checkbox"/> Unrelated housemates | <input type="checkbox"/> Prefer not to answer   |
| <input type="checkbox"/> Sole member                     | <input type="checkbox"/> Siblings             | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Grandparents with grandchildren | <input type="checkbox"/> Single parent        |   |

**What is your HOMELESS STATUS?**

- |                                       |  |                                  |  |
|---------------------------------------|--|----------------------------------|--|
| <input type="checkbox"/> Not homeless | <input type="checkbox"/> Homeless/no address | <input type="checkbox"/> Shelter | <input type="checkbox"/> Other temporary |
|---------------------------------------|--|----------------------------------|--|

**What is your MOTHER TONGUE?**

- |                                 |                                  |   |
|---------------------------------|----------------------------------|---|
| <input type="checkbox"/> French | <input type="checkbox"/> English | <input type="checkbox"/> Other (specify): _____ |
|---------------------------------|----------------------------------|---|

If other, which of two official languages are you most comfortable communicating in?  French  English

What is your **RACIAL OR ETHNIC GROUP?**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> White - North American | <input type="checkbox"/> Asian - East           | <input type="checkbox"/> Middle Eastern         |
| <input type="checkbox"/> White - European       | <input type="checkbox"/> Asian - South          | <input type="checkbox"/> Mixed Heritage         |
| <input type="checkbox"/> First Nations          | <input type="checkbox"/> Asian - South-East     | <input type="checkbox"/> Do not know            |
| <input type="checkbox"/> Indigenous/Aboriginal  | <input type="checkbox"/> Black - African        | <input type="checkbox"/> Prefer not to answer   |
| <input type="checkbox"/> Inuit                  | <input type="checkbox"/> Black - Caribbean      | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Metis                  | <input type="checkbox"/> Black - North American |   |
| <input type="checkbox"/> Latino American        | <input type="checkbox"/> Indian - Caribbean     |   |

What is your country of origin? \_\_\_\_\_

Date/year of arrival in Canada (if applicable)? \_\_\_\_\_

What is your **RELIGION?**

- |   |                                    |   |
|---|------------------------------------|---|
| <input type="checkbox"/> Catholic           | <input type="checkbox"/> Jewish    | <input type="checkbox"/> Eastern religions        |
| <input type="checkbox"/> Protestant         | <input type="checkbox"/> Buddhist  | <input type="checkbox"/> No religious affiliation |
| <input type="checkbox"/> Christian Orthodox | <input type="checkbox"/> Mennonite | <input type="checkbox"/> Do not know              |
| <input type="checkbox"/> Christian          | <input type="checkbox"/> Hindu     | <input type="checkbox"/> Prefer not to answer     |
| <input type="checkbox"/> Muslim             | <input type="checkbox"/> Sikh      | <input type="checkbox"/> Other (specify): _____   |

Do you have any of the following **DISABILITIES?**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Chronic illness                 | <input type="checkbox"/> Learning disability      | <input type="checkbox"/> Mental illness         |
| <input type="checkbox"/> Physical disability             | <input type="checkbox"/> Developmental disability | <input type="checkbox"/> Do not know            |
| <input type="checkbox"/> Dependence<br>(drug or alcohol) | <input type="checkbox"/> Sensory disability       | <input type="checkbox"/> Prefer not to answer   |
|  |   | <input type="checkbox"/> Other (specify): _____ |

INFORMATION REGARDING YOUR WELLBEING.

How would you describe your **SENSE OF BELONGING TO COMMUNITY?**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Very strong     | <input type="checkbox"/> Somewhat weak | <input type="checkbox"/> Do not know          |
| <input type="checkbox"/> Somewhat strong | <input type="checkbox"/> Very weak     | <input type="checkbox"/> Prefer not to answer |

Self-assessment of **PHYSICAL HEALTH:**

- |                                    |                                      |   |
|------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Fair        | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Very good | <input type="checkbox"/> Poor        |   |
| <input type="checkbox"/> Good      | <input type="checkbox"/> Do not know |   |

Self-assessment of **MENTAL HEALTH:**

- |                                    |                                      |   |
|------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Fair        | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Very good | <input type="checkbox"/> Poor        |   |
| <input type="checkbox"/> Good      | <input type="checkbox"/> Do not know |   |

## Electronic Communications and Videoconference Consent Form

The Centre de santé communautaire de l'Estrie (CSCE) uses various means of communication to correspond with its clientele, such as email or videoconference.

**Although email and videoconference has several benefits, it includes certain risks which you need to understand.**

Please read the following information. The CSCE wishes to ensure that you understand the risks before authorizing us to keep your email address on file:

- Email communication or videoconference are not considered to be private or secure;
- Your electronic communications at work may be monitored;
- Email is easier to forge than a hand-signed paper copy;
- It is impossible to verify the actual identity of the sender or to ensure that only one recipient can read the email;
- Any email received could potentially introduce a virus in your computer system;
- Emails can be transferred, intercepted, broadcast, recorded or even changed without your knowledge;
- The sender can send an email to the wrong address by mistake;
- Emails cannot be deleted. Even if copies of an email have been deleted by the sender and recipient, backup copies can exist within the computer system or on the internet.

To minimize some of these risks, the two parties agree to the following responsibilities:

### Responsibilities of the CSCE

As an organization, the CSCE is subject to the standards of the Personal Health Information Protection Act, 2004. As such, all staff has signed and respects the policy on the protection of personal information (PS02) which ensures the accuracy and confidential nature of personal information that it obtains in the course of its activities. To this end, measures are taken to secure your personal information.

All of our clients' email addresses are stored in our secure electronic health record platform, protected by passwords. All communications between the electronic systems used at the centre and the centre's server are coded with the "Secure Socket Layer" (SSL) protocol. Firewalls also prevent unauthorized access to our system's network and block spam, viruses and other undesirable content before they reach our infrastructure and users.

### Client Responsibilities

Clients must provide us with a private email address that is not accessible to anyone else. They must ensure that their email address is protected by software encoding, or they should understand that there is an increased risk of private information being violated. Clients that change their email address need to inform the CSCE as soon as possible.

We take your health and well-being seriously. Thank you for your confidence in us.

**The decision to communicate with clients by email or videoconference remains at the discretion of each CSCE professional. Some may prefer not to use electronic communication.**

**As such, the agreement signed today strictly concerns you and the professional mentioned below. However, for the Diabetes Education Program or a group, this same agreement may authorize several professionals to communicate with you by email or videoconference.**

*For persons 16 years of age and over:*

I, \_\_\_\_\_, agree and accept:

To receive emails or videoconference from the following professional(s):

\_\_\_\_\_  
Yes  No

My email address is: \_\_\_\_\_

*For parents or guardians (children under 16 years of age) or other legal guardians:*

My name is: \_\_\_\_\_

My relationship with the client is: \_\_\_\_\_

On behalf of, \_\_\_\_\_, I agree and accept:

To receive emails or videoconference from the following professional(s):

\_\_\_\_\_  
Yes  No

My email address is: \_\_\_\_\_

**Date:** \_\_\_\_\_

**Client's signature:** \_\_\_\_\_

**Professional's signature:** \_\_\_\_\_

Physical activity improves your physical and mental health. Even small amounts of physical activity are good, and more is better.

For almost everyone, the benefits of physical activity far outweigh any risks. For some individuals, specific advice from a Qualified Exercise Professional (QEP – has post-secondary education in exercise sciences and an advanced certification in the area – see [csep.ca/certifications](http://csep.ca/certifications)) or health care provider is advisable. This questionnaire is intended for all ages – to help move you along the path to becoming more physically active.

- I am completing this questionnaire for myself.
- I am completing this questionnaire for my child/dependent as parent/guardian.

## PREPARE TO BECOME MORE ACTIVE

The following questions will help to ensure that you have a safe physical activity experience. Please answer **YES** or **NO** to each question before you become more physically active. If you are unsure about any question, answer **YES**.

**1** Have you experienced **ANY** of the following (A to F) **within the past six months**?

- A** A diagnosis of/treatment for heart disease or stroke, or pain/discomfort/pressure in your chest during activities of daily living or during physical activity?
- B** A diagnosis of/treatment for high blood pressure (BP), or a resting BP of 160/90 mmHg or higher?
- C** Dizziness or lightheadedness during physical activity?
- D** Shortness of breath at rest?
- E** Loss of consciousness/fainting for any reason?
- F** Concussion?

**2** Do you currently have pain or swelling in any part of your body (such as from an injury, acute flare-up of arthritis, or back pain) that affects your ability to be physically active?

**3** Has a health care provider told you that you should avoid or modify certain types of physical activity?

**4** Do you have any other medical or physical condition (such as diabetes, cancer, osteoporosis, asthma, spinal cord injury) that may affect your ability to be physically active?

..... ➤ **NO** to all questions: go to Page 2 – ASSESS YOUR CURRENT PHYSICAL ACTIVITY .....

**YES** to any question: go to Reference Document – ADVICE ON WHAT TO DO IF YOU HAVE A YES RESPONSE ... ➤ ➤



## ASSESS YOUR CURRENT PHYSICAL ACTIVITY

Answer the following questions to assess how active you are now.

- 1 During a typical week, on how many days do you do moderate- to vigorous-intensity aerobic physical activity (such as brisk walking, cycling or jogging)?  DAYS/  
WEEK
  - 2 On days that you do at least moderate-intensity aerobic physical activity (e.g., brisk walking), for how many minutes do you do this activity?  MINUTES/  
DAY
- For adults, please multiply your average number of days/week by the average number of minutes/day:  MINUTES/  
WEEK

Canadian Physical Activity Guidelines recommend that adults accumulate at least 150 minutes of moderate- to vigorous-intensity physical activity per week. For children and youth, at least 60 minutes daily is recommended. Strengthening muscles and bones at least two times per week for adults, and three times per week for children and youth, is also recommended (see csep.ca/guidelines).



## GENERAL ADVICE FOR BECOMING MORE ACTIVE

Increase your physical activity gradually so that you have a positive experience. Build physical activities that you enjoy into your day (e.g., take a walk with a friend, ride your bike to school or work) and reduce your sedentary behaviour (e.g., prolonged sitting).

If you want to do **vigorous-intensity physical activity** (i.e., physical activity at an intensity that makes it hard to carry on a conversation), and you do not meet minimum physical activity recommendations noted above, consult a Qualified Exercise Professional (QEP) beforehand. This can help ensure that your physical activity is safe and suitable for your circumstances.

Physical activity is also an important part of a healthy pregnancy.

Delay becoming more active if you are not feeling well because of a temporary illness.



## DECLARATION

To the best of my knowledge, all of the information I have supplied on this questionnaire is correct.  
If my health changes, I will complete this questionnaire again.

I answered **NO** to all questions on Page 1



Sign and date the Declaration below



I answered **YES** to any question on Page 1

Check the box below that applies to you:

- I have consulted a health care provider or Qualified Exercise Professional (QEP) who has recommended that I become more physically active.
- I am comfortable with becoming more physically active on my own without consulting a health care provider or QEP.




Name (+ Name of Parent/Guardian if applicable) [Please print]

Signature (or Signature of Parent/Guardian if applicable)

Date of Birth

Date

Email (optional)

Telephone (optional)

**With planning and support you can enjoy the benefits of becoming more physically active. A QEP can help.**

- Check this box if you would like to consult a QEP about becoming more physically active.  
(This completed questionnaire will help the QEP get to know you and understand your needs.)

Use this reference document if you answered **YES** to any question and you have not consulted a health care provider or Qualified Exercise Professional (QEP) about becoming more physically active.

<b>1 Have you experienced ANY of the following (A to F) within the past six months?</b>	
<p><b>A</b> A diagnosis of/treatment for heart disease or stroke, or pain/discomfort/pressure in your chest during activities of daily living or during physical activity?</p> <p><input type="checkbox"/> <b>YES</b></p>	<p>Physical activity is likely to be beneficial. If you have been treated for heart disease but have not completed a cardiac rehabilitation program within the past 6 months, consult a doctor – a supervised cardiac rehabilitation program is strongly recommended. If you are resuming physical activity after more than 6 months of inactivity, begin slowly with light- to moderate-intensity physical activity. If you have pain/discomfort/pressure in your chest and it is new for you, talk to a doctor. Describe the symptom and what activities bring it on.</p>
<p><b>B</b> A diagnosis of/treatment for high blood pressure (BP), or a resting BP of 160/90 mmHg or higher?</p> <p><input type="checkbox"/> <b>YES</b></p>	<p>Physical activity is likely to be beneficial if you have been diagnosed and treated for high blood pressure (BP). If you are unsure of your resting BP, consult a health care provider or a Qualified Exercise Professional (QEP) to have it measured. If you are taking BP medication and your BP is under good control, regular physical activity is recommended as it may help to lower your BP. Your doctor should be aware of your physical activity level so your medication needs can be monitored. If your BP is 160/90 or higher, you should receive medical clearance and consult a QEP about safe and appropriate physical activity.</p>
<p><b>C</b> Dizziness or lightheadedness during physical activity</p> <p><input type="checkbox"/> <b>YES</b></p>	<p>There are several possible reasons for feeling this way and many are not worrisome. Before becoming more active, consult a health care provider to identify reasons and minimize risk. Until then, refrain from increasing the intensity of your physical activity.</p>
<p><b>D</b> Shortness of breath at rest</p> <p><input type="checkbox"/> <b>YES</b></p>	<p>If you have asthma and this is relieved with medication, light to moderate physical activity is safe. If your shortness of breath is not relieved with medication, consult a doctor.</p>
<p><b>E</b> Loss of consciousness/fainting for any reason</p> <p><input type="checkbox"/> <b>YES</b></p>	<p>Before becoming more active, consult a doctor to identify reasons and minimize risk. Once you are medically cleared, consult a Qualified Exercise Professional (QEP) about types of physical activity suitable for your condition.</p>
<p><b>F</b> Concussion</p> <p><input type="checkbox"/> <b>YES</b></p>	<p>A concussion is an injury to the brain that requires time to recover. Increasing physical activity while still experiencing symptoms may worsen your symptoms, lengthen your recovery, and increase your risk for another concussion. A health care provider will let you know when you can start becoming more physically active, and a Qualified Exercise Professional (QEP) can help get you started.</p>

After reading the **ADVICE** for your **YES** response, go to **Page 2** of the *Get Active Questionnaire – ASSESS YOUR CURRENT PHYSICAL ACTIVITY*

Use this reference document if you answered **YES** to any question and you have not consulted a health care provider or Qualified Exercise Professional (QEP) about becoming more physically active.

**2 Do you currently have pain or swelling in any part of your body (such as from an injury, acute flare-up of arthritis, or back pain) that affects your ability to be physically active?**

**YES**

If this swelling or pain is new, consult a health care provider. Otherwise, keep joints healthy and reduce pain by moving your joints slowly and gently through the entire pain-free range of motion. If you have hip, knee or ankle pain, choose low-impact activities such as swimming or cycling. As the pain subsides, gradually resume your normal physical activities starting at a level lower than before the flare-up. Consult a Qualified Exercise Professional (QEP) in follow-up to help you become more active and prevent or minimize future pain.

**3 Has a health care provider told you that you should avoid or modify certain types of physical activity?**

**YES**

Listen to the advice of your health care provider. A Qualified Exercise Professional (QEP) will ask you about any considerations and provide specific advice for physical activity that is safe and that takes your lifestyle and health care provider's advice into account.

**4 Do you have any other medical or physical condition (such as diabetes, cancer, osteoporosis, asthma, spinal cord injury) that may affect your ability to be physically active?**

**YES**

Some people may worry if they have a medical or physical condition that physical activity might be unsafe. In fact, regular physical activity can help to manage and improve many conditions. Physical activity can also reduce the risk of complications. A Qualified Exercise Professional (QEP) can help with specific advice for physical activity that is safe and that takes your medical history and lifestyle into account.

After reading the ADVICE for your YES response, go to Page 2 of the *Get Active Questionnaire – ASSESS YOUR CURRENT PHYSICAL ACTIVITY*

## WANT ADDITIONAL INFORMATION ON BECOMING MORE PHYSICALLY ACTIVE?

▶ [csep.ca/certifications](https://csep.ca/certifications)

CSEP Certified members can help you with your physical activity goals.

▶ [csep.ca/guidelines](https://csep.ca/guidelines)

Canadian Physical Activity Guidelines for all ages.