Appendix C

BRIEF HEALTH QUESTIONNAIRE (BHQ) - Caregiver

Name: __________________________
Address: __________________________
________________________________
Phone: (   ) ____________ (W)
Phone: (   ) ____________ (H)

Age: ________________
DOB: ________________

Relationship to Child: ________________

Please read the following questions very carefully. If you have any difficulty please advise the health professional.

1. **Personal medical history.** Indicate symptoms that apply to you.
   - □ Pain or discomfort in chest following exercise
   - □ Poor exercise tolerance
   - □ Frequent dizziness
   - □ Frequent headaches
   - □ Frequent backache
   - □ Frequent aches or pains in an joints

       Details __________________________

   - □ Other current symptoms that exercise may affect

       Details __________________________

2. **Lungs: Do you have any of the following conditions?**
   - Asthma
     - □ Yes
     - □ No

       Details __________________________

   - Emphysema
     - □ Yes
     - □ No

       Details __________________________

   - Bronchitis
     - □ Yes
     - □ No

       Details __________________________
Shortness of Breath
☐ Yes
☐ No
Details __________________________

3. Do you have any heart condition/problems that might preclude you from exercise?
☐ Yes
☐ No
Details __________________________

4. Seizures, fainting, blackouts and loss of consciousness?
☐ Yes
☐ No
Details __________________________

5. Headaches
☐ Yes
☐ No
Details __________________________

6. Sight or hearing difficulties
☐ Yes
☐ No
Details __________________________

7. Cervical Spine instability (e.g. Atlanto-axial)
☐ Yes
☐ No
Details __________________________

8. Spinal problems that cause pain or preclude exercise
☐ Yes
☐ No
Details __________________________

9. Are you pregnant?
☐ Yes (number of weeks __; due_______)
☐ No
Details __________________________

10. Medication. Are you taking any medication prescribed by your Doctor or other Health Care provider? If so, list details, i.e., type of drugs, dosage.

______________________________
______________________________
______________________________
BRIEF HEALTH QUESTIONNAIRE – Child (caregiver report)

Name (child): __________________________
Address: ____________________________________________
________________________________________
Phone: ( ) ________________ (W)
Phone: ( ) ________________ (H)
Age: ________________
DOB: ________________

Please read the following questions very carefully. If you have any difficulty please advise the health professional.

1. **Personal medical history.** Indicate symptoms that apply to you.
   - [ ] Pain or discomfort at rest or with exercise
     
     Details __________________________

   - [ ] Frequent dizziness
   - [ ] Frequent colds or flu
   - [ ] Frequent headaches
   - [ ] Frequent backache
   - [ ] Other current symptoms that exercise may affect
     
     Details __________________________

2. **Seizures, fainting, blackouts and loss of consciousness?**
   - [ ] Yes
   - [ ] No
     
     Details __________________________

3. **Headaches**
   - [ ] Yes
   - [ ] No
     
     Details __________________________

4. **Sight or hearing difficulties**
   - [ ] Yes
   - [ ] No
     
     Details __________________________

5. **Cervical Spine instability (e.g. Atlanto-axial)**
   - [ ] Yes
   - [ ] No
     
     Details __________________________
6. **Spinal problems that cause pain or preclude exercise**
   - [ ] Yes
   - [ ] No
   Details _______________________

7. **Medication.** Are you taking any medication prescribed by your Doctor or other Health Care provider? If so, list details, i.e., type of drugs, dosage.

   _____________________________________________________________

   _____________________________________________________________

   _____________________________________________________________