INTERNATIONAL KARATE ORGANIZATION KYOKUSHINKAIKAN, CANADA

Kyokushin Karate Pre-participation Questionnaire:

The following questionnaire is designed to screen for conditions, which may increase your risk during the intense physical training and bodily contact, which is part of Kyokushin Karate. **Be assured that the information will be treated with the utmost confidentiality**. This requirement is for your safety only. If you have concerns about this, please feel free to discuss this with your instructor.

Name: _____

Email: _____ Phone:_____

BC Medical Services Plan #: _____

*If your answer to ANY of the following questions is **YES;** the IKOK-C may require clearance from a physician to allow you to participate.*

Yes ___ No ___ Are you over 40 (male) or over 50 (female)?

Yes ___ No ___ 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 ___ Do you feel pain in your chest when you do physical activity?

Yes ___ No ___ In the past month have you had chest pain when you were not doing physical activity?

Yes ___ No ___ Do you lose your balance because of dizziness or do you ever lose consciousness?

Yes ___ No ___ Do you have a bone or joint problem (e.g. back, knee or hip) that could be made worse by a change in your physical activity?

Yes ___ No ___ Is your doctor currently prescribing drugs for any heart condition such as blood pressure or irregular heart rate?

Yes ___ No ___ Are you on any medication that may influence your ability or the advisability of participating in strenuous activities or contact sport?

Yes ___ No ___ Do you know of any other reason why you should not do physical activity?

The above questions were adapted for use by IKOK-C from the Physical Readiness Questionnaire (PAR-Q) and from the recommendations of the Committee on Exercise, Rehabilitation and Prevention, Council on Clinical Cardiology, American Heart Association, as well as the 36th Bethesda Conference on the Eligibility Recommendations for Competitive Athletes with Cardiovascular Abnormalities

Please complete other side

Do you use:

- ❑ Glasses or contact lenses Yes ___ No ___
- ❑ Hearing aid(s) Yes ___ No ___
- ❑ Have you ever been knocked unconscious? Yes ___ No ___
- ❑ Have you previously sustained any ***serious*** injury or event for which you sought medical or other treatment? Yes ___ No ___

Do you have any of the following medical conditions:

- ❑ Mental health difficulties (e.g. depression, anxiety) Yes ___ No ___
- ❑ Connective tissue disease (such as Marfan's disease or Ehlers-Danlos syndrome or variants thereof) Yes ___ No ___
- ❑ Vascular disease, trouble with circulation, bleeding disorders Yes ___ No ___
- ❑ Breathing problems (e.g. bronchitis, asthma) Yes ___ No ___
- ❑ Endocrine disorders (e.g. hyperthyroidism, hypothyroidism) Yes ___ No ___
- ❑ Seizures or convulsions Yes ___ No ___
- ❑ Diabetes Yes ___ No ___
- ❑ Arthritis (joint pain) Yes ___ No ___
- ❑ Anaemia (low red blood cell count) Yes ___ No ___
- ❑ Cancer Yes ___ No ___
- ❑ Infectious disease (e.g. TB, HIV, and Hepatitis) Yes ___ No ___
- ❑ Severe allergies Yes ___ No ___
- ❑ Have you ever had surgery to your eye(s); including cornea, eyeball or retina? Yes ___ No ___
- ❑ Are you pregnant? Yes ___ No ___
- ❑ Do you have any chronic illness or condition? Yes ___ No ___
  If so, please specify:

_____

Please mention anything else you would like us to know about your health:

_____

_____

Please provide the name, phone number and address of your family doctor or other currently treating physician:

_____

_____

Signed: _____

Signed (Parent or guardian if under 19): _____

Date: _____

Please complete other side