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.

_____

_____

_____

_____