

ID: _____

Personalized Exercise Questionnaire (PEQ)

PLEASE READ THESE INSTRUCTIONS BEFORE STARTING:

This survey was created to better understand your **exercise needs** and **goals**. By completing this survey you will help us understand some of the difficulties you face in an exercise program. This information will be used to help us create better exercise/ physical activity program for you.

There are **6 sections** and **38 questions**. Please complete **ALL** questions relevant to you. **All answers will be kept strictly confidential and never associated with your name**

SECTION ONE: My Support Network

	No	Not Sure	Yes	Not Applicable
1. I prefer someone to supervise/ assist me with an exercise:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES , under a:				
<input type="checkbox"/> Healthcare professional (e.g. physiotherapist)				
<input type="checkbox"/> Personal Trainer				
<input type="checkbox"/> Other: _____				
2. A healthcare provider (e.g. physiotherapist, nurse, etc.) with a good attitude toward exercise is important to me:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Having friends/family with a good attitude toward exercise is important to me:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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SECTION TWO: My Access to Exercise

	No	Not Sure	Yes	Not Applicable
4. I have a place to exercise (indoor or outdoor) at home, place of work or near my home/work place:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If **YES**, how far:

- At home or at work
- < 5 km (< 3 miles)
- 5 – 10 km (3-6 miles)

5. I am able to get to an exercise site on my own: (Check “Not Applicable” if you exercise at home)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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If **NO**, who could you ask:

- Family member/partner
- Friend
- Other: _____

6. I have transportation to an exercise site: (Check “Not Applicable” if you exercise at home)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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If **YES**, type of transportation:

- Bike
- Motor Vehicle (e.g. car)
- Public transportation
- Walking

7. I have a safe place to exercise: (e.g. proper space to exercise, dry and clean floors, good lighting, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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8. I have an encouraging place to exercise: (e.g. pleasant people that motivate me)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	No	Not Sure	Yes	Not Applicable
9. I have an exercise location that is free of cost or reasonably priced (including parking fees):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION THREE: My Exercise Goals

How important are the following GOALS to YOU in an exercise program?

	Not Important	Somewhat Important	Very Important	Not Applicable
10. Feel less tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Be able to walk longer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Be more flexible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Have better balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Fall less often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Have less pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Increase muscle strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. What is your MOST important exercise goal?

SECTION FOUR: My Exercise Preferences

18. Please list up to 3 things that HELP you to exercise more often:

1. _____
2. _____
3. _____

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19. Where would you like your exercise program to be? (Check ALL that apply)

- Home
- Gym (e.g. YMCA/YWCA, Goodlife Fitness, Wynn Fitness, etc.)
- Mall
- Community Centre
- Outdoors (e.g. parks, trails, sidewalks, etc.)
- Other: _____

20. What is the best time for you to exercise? (Check ALL that apply)

- Morning (between 6:00 am to 12:00 pm)
- Afternoon (between 12:00 pm to 6:00 pm)
- Evening (between 6:00 pm to 11:00 pm)

21. What is your preferred exercise schedule? (Check ALL that apply)

- Fixed time (same class offered at same time during the week)
- Multiple drop-in times (same class offered at different times of the week)
- On my own time

22. What is your preferred exercise class size? (Check ALL that apply)

- I prefer to exercise alone
- With a partner/trainer
- Small group (less than 10 people)
- Large group (more than 10 people)
- Does not matter

23. How would you like to learn proper exercise technique? (Check ALL that apply)

- Taught by a healthcare professional (e.g. physiotherapist, nurse, etc.)
- Taught by a trainer/health club staff
- Learn on my own from an exercise video
- Learn on my own from a website with pictures
- Learn on my own using an app
- Learn on my own using a print handout
- Have a friend teach me
- Have another person with osteoporosis teach me
- None of the above

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24. What level of exercise are you comfortable doing? (Check **ALL** that apply)

- Easy to perform
- Challenging to perform (i.e. "I like a challenge")
- Slow paced exercises
- Fast paced exercises
- Easy to remember

SECTION FIVE: My Feedback and Tracking

25. I would like to receive feedback about my progress:

- YES
- NO

If **YES**, by: (Check **ALL** that apply)

- Email
- In person
- Social media (e.g. Twitter, Facebook, etc.)
- Phone call
- Text message

*If you answered **YES** to question 25, please complete questions 26 and 27.*

*If you answered **NO** to question 25, please skip to question 28.*

26. What type of feedback would you like to receive? (Check **ALL** that apply)

- Regarding my exercise progress and future improvements
- Regarding proper exercise techniques
- Other: _____

27. How often would you like to receive feedback about your exercise progress? (Please check only **ONE** answer)

- Daily
- Weekly
- Monthly
- Yearly

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28. I would like to give feedback on the exercise program:

- YES
- NO

If **YES**, by (Check **ALL** that apply):

- Email
- In person
- Social media (e.g. Twitter, Facebook, etc.)
- Phone call
- Text message

29. I would like to track my exercise progress:

- YES
- NO

If **YES**, using (Check **ALL** that apply):

- Cellphone/mobile
- Diary/Log book
- Wearable technology (e.g. Fit Bit, pedometer, watch etc.)
- Other: _____

SECTION SIX: My Barriers to Exercise

30. Do you have things that STOP you from exercising?

- Yes
- No

If **YES**, how often does it stop you from exercising: (Check **only ONE** answer)

- Always
- Very often
- Sometimes
- Rarely

31. Please list up to 3 things that STOP you from exercising more often:

1. _____
2. _____
3. _____

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32. I do not exercise as often as I like because: (Check ALL that apply)

- I do not like exercise
- I do not want to fall
- I do not want to injure myself (e.g. breaking a bone or bruising)
- I feel pain when I exercise
- I feel bored when exercising
- Other: _____
- None of the above

33. I do not exercise as often as I like because I have difficulty: (Check ALL that apply)

- Understanding the exercise
- Performing the exercise (i.e. I do not know how to exercise safely)
- Other: _____
- None of the above

34. I do not exercise as often as I like because I do not have: (Check ALL that apply)

- A place to exercise
- Confidence (e.g. I feel self-conscious about my body)
- Finances
- Mobility (e.g. limited movements due to pain)
- Proper quality of sleep
- Transportation
- Time (e.g. family priorities, work, etc.)
- Willpower/motivation
- Other: _____
- None of the above

35. Do weather conditions stop you from exercising as often as you like? (Check only ONE answer)

- Always
- Very often
- Sometimes
- Rarely
- Never

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36. I do not exercise as often as I like because I have medical conditions such as: (Check **ALL** that apply)

- Arthritis (e.g. hips, knees, etc.)
- Cognitive concerns (e.g. Alzheimer, Dementia, Parkinson, etc.)
- Heart condition (e.g. angina, heart failure, etc.)
- Kidney disease (e.g. dialysis)
- Lung disease (e.g. asthma, COPD, etc.)
- Mental health issues (e.g. anxiety, depression, etc.)
- Other: _____
- None of the above

37. If you had fewer barriers would you spend more time exercising? (Please check only **ONE** answer)

- Yes
- No
- Not sure

38. Please check any mobility aids that you normally use:

- Cane
- Walker
- Crutches
- Wheelchair
- Other: _____
- None

😊 End 😊