



For More Information Please Call:

Phone: (250) 591-8524

E-mail: Info@choose2be.ca

Please ensure that all questions are answered complete with phone numbers, medical contact information. All information is kept confidential.

HEALTH QUESTIONNAIRE		
Name:	Date of Birth:	Age:
Address:		
City:	Province:	
Home phone:	Work phone:	
Email:	Employer:	
Occupation:		
In case of emergency, please notify: Name:		
Relationship:	City:	
Home phone:	Work phone:	

Regular exercise associated with many health benefits, yet any change of activity may increase the risk of injury. Please read each question carefully and answer every question honestly:

- Yes: No: Has a physician ever said you have a heart condition and you should only do physical activity recommended by a physician?
- Yes: No: When you do physical activity, do you feel pain in your chest?
- Yes: No: When you were not doing physical activity, have you had chest pain in the past month?
- Yes: No: Do you ever lose consciousness or do you lose your balance because of dizziness?
- Yes: No: Do you have a joint or bone problem that may be made worse by a change in your physical activity?
- Yes: No: Is a physician currently prescribing medications for your blood pressure or heart condition?
- Yes: No: Do you have insulin dependent diabetes?
- Yes: No: Have you seen a physiotherapist or chiropractor in the last 12 months?
- Yes: No: Do you have any history of problems with your back?
- Yes: No: If applicable, are you pregnant?
- Yes: No: Do you know of any other reason you should not exercise or increase your physical activity?

If you answered yes to any of the above questions, you must talk with your doctor BEFORE you become more physically active. If you honestly answered no to all questions you should increase your level of physical activity gradually. If your health changes so you then answer yes to any of the above questions, seek guidance from a physician.

Please tell us of any other injuries old or new we should be aware of:

PLEASE CHECK THE BOX FOR THE APPROPRIATE ANSWER	
Has your doctor ever said you have heart trouble?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Have you ever had angina pectoris, sharp pain or heavy pressure in your chest as a result of exercise, walking, or other physical activity such as climbing stairs? <i>(does not include the normal out of breath feeling that results from normal activity)</i>	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Do you experience any sharp pain or extreme tightness in your chest when you are hit with a cold blast of air?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Have you ever experience rapid heart action or palpitations?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Have you ever had a real suspected heart attack, coronary occlusion, myocardial infarction, coronary insufficiency, or thrombosis?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Have you ever had rheumatic fever?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Do you have diabetes, hypertension, or high blood pressure?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Does anyone in your family have diabetes, hypertension, or high blood pressure?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Has more than one blood relative (parent, sibling, first cousin) had a heart attack or coronary artery disease before the age of 60?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Have you ever taken medications or been on a special diet to lower your cholesterol?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Have you ever taken digitalis, quinine, or any other drug for your heart?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Have you ever taken nitroglycerine or any other tablets for chest pain? (tablet that you place under your tongue)	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Are you overweight?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Are you under a lot of stress?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Do you drink alcohol excessively?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Do you smoke cigarettes?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Do you have a physical condition, impairment or disability, including a joint or muscle problem, that should be considered before you undertake an exercise program?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Are you more than 65 years old?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Are you more than 35 years old?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Do you exercise fewer than tree times per week?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>

MEDICAL INFORMATION	
Physician:	Phone:
Are you under the care of a physician, chiropractor, massage therapist or any other health care Professional for any reason?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Are you taking any medications? <i>If yes please indication the following: dosage/frequency, reason for taking and type:</i>	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Please list any allergies?	
Has your doctor ever said your blood pressure was too high?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Are you accustomed to vigorous exercise?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Is there any reason not mentioned why you should not follow a regular exercise program?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Have you recently experienced any chest pain associated with either exercise or stress?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>
If you smoke or are a former smoker, please answer the following questions: If you are a former smoker, when did you quit? Do you smoke cigar and or pipe? How many cigarettes a day do you smoke on average?	

FAMILY AND PERSONAL MEDICAL HISTORY

If there is a family history for any condition, please check the box to the left. If you are personally experiencing any of these conditions, fill the box to the right.

- | | | | |
|---|--------------------------|-------------|-----------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> | | |
| <input type="checkbox"/> Respiratory/Pulmonary conditions | <input type="checkbox"/> | | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> | Type: _____ | How long: _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> | | |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> | | |

LIFESTYLE AND DIETARY FACTORS

Please fill in the information below:

- | | | | |
|--|------------------------------|---------------------------------|-------------------------------|
| <input type="checkbox"/> Occupational stress level | <input type="checkbox"/> Low | <input type="checkbox"/> Medium | <input type="checkbox"/> high |
| <input type="checkbox"/> Energy level | <input type="checkbox"/> Low | <input type="checkbox"/> Medium | <input type="checkbox"/> high |
| <input type="checkbox"/> Caffeine intake per day: | _____ | | |
| <input type="checkbox"/> Alcohol intake per week: | _____ | | |
| <input type="checkbox"/> Colds per year: | _____ | | |
| <input type="checkbox"/> EGastrointestinal disorder: | | | |
| <input type="checkbox"/> Anemia | | | |
| <input type="checkbox"/> Hypoglycemie | | | |
| <input type="checkbox"/> Thyroid disorder | | | |
| <input type="checkbox"/> Pre or postnatal | | | |

CARDIOVASCULAR

- | | | |
|--|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hypertension | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Hearth disease | <input type="checkbox"/> Hearth attack |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Stoke | <input type="checkbox"/> Gout |

MUSCULOSKELETAL INFORMATION

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain or general discomfort. (head, neck, upper back, shoulder, arm, elbow, wrist, hand, lower back, hip, pelvis, thigh, knee, arthritis, hernia, surgeries....)

NUTRITIONAL INFORMATION

Are you on any specific food/diet plan at this time? Yes No

If yes, please describe:

Do you experience any frequent weight fluctuations? Yes No

Have you experience a recent weight gain or loss? Yes No

If yes, please describe, and how long ago:

Other food/nutritional issues:

WORK AND EXERCISE HABITS

How would you describe work: Intense Moderate Sedentary
 How would you describe your free time: Intense Moderate
 Sedentary

To what degree do you perceive your environment as stressful?

Work: Minimal Moderate Average Extremely
 Home: Minimal Moderate Average Extremely

Do you work more than 40 hours per week? Yes No

Are you currently in a regular exercise program? Yes No

Do you regularly walk or run 2 or more kilometres continuously? Yes No

Do you practice weightlifting? Yes No

Do you frequently compete in a competitive sports? Yes No

Which one: _____

Average number of times per week: _____

Which sports did you participate in college and/or high school? _____

Do you frequently participate in sports? Yes No

Which one: _____

Any other comments you feel are pertinent to your exercise program:

INFORMED CONSENT FORM

I, (print name) _____,
 give my consent to participate in a physical fitness program.

Benefits

Participation in a regular program of physical activity has been shown to produce positive changes in a number of organ systems. These changes include increased work capacity, improved cardiovascular efficiency, and increased muscular strength, flexibility, power and endurance. I recognize that exercise carries some risk to the musculoskeletal system (sprains, strains) and the cardiorespiratory system (dizziness, discomfort in breathing, heart attack). I hereby certify that I know of no medical problem (except those noted below) that would increase my risk of illness and injury as a result of participation in a regular exercise program.

Testing and evaluation results

I understand that I will undergo initial testing to determine my current physical fitness status. The testing will consist of completing this health inventory, a musculoskeletal assessment and body composition. I further understand that such screening is intended to provide Choose2be with essential information used in the development of individual fitness programs. I understand that my individual results will be made available only to me. I also understand that the testing is not intended to replace any other medical test or the services of my physician. I will be provided a copy of all test results. I may share the results with whomever I please, including my personal physician. By signing this consent form I understand that I am personally responsible for my actions during my tenure at Choose2be and that I waive the responsibility of this center if I should incur any injury as a result of my negligence.

Name: _____

Signature: _____

Date: _____

Witness: _____

APPLICANT'S PERMISSION TO RELEASE INFORMATION

Applicant Name: _____
Applicant date of birth: _____
Applicant address: _____

I Hereby Give Permission to contact the following individuals, as required, for the development of a Fitness and Rehabilitation Program:

- _____
-
- _____
-
- _____
-

To release any pertinent information to Choose2be Health Management Services for the purpose of fitness and rehabilitation programming. I further authorize Choose2be Health Management Services to release information to such agencies and persons as may be required to assist in the safe development and implementation of fitness and rehabilitation programs. If you have any questions about the collection or use of this information contact your Rehabilitation Consultant.

Applicant's signature: _____
Date Signed: _____

Physical Evaluation Result:

1- shoulder range of motion

2- chest & anterior deltoid

3- cervical spine range of motion

4- lateral movement of the head, lateral range of motion

5- sit edge of table, lie back down while holding one knee to chest

6- spinal stability test: lying back bend knee, feet flat ground

7- core strength & endurance

APPLICANT'S AGREEMENT AND RELEASE OF LIABILITY

Applicant name: _____
Applicant address: _____

In consideration of being allowed to participate in any way in the activities and programs of Choose2be and use of its facilities, equipment and machinery, the undersigned acknowledges, appreciates and agrees that:

1. The risk of injury from the activities involved in this program including strength, flexibility and aerobic exercise and the use, supervised and unsupervised, of training equipment is significant, including the potential for permanent paralysis & death, and while particular rules, equipment, & personal discipline may reduce this risk, the risk of injury does exist; and,
2. I understand this program does not provide medical treatment, nor are its fitness professionals licensed medical professionals.
3. I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, EVEN ARISING FROM THE NEGLIGENCE OF THE RELEASEES or others, and assume full responsibility for my participation; and,
4. I willingly agree to comply, with the stated and customary terms and conditions for participation. If however I observe any unusual significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest representative of Choose2be immediately; and
5. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HEREBY RELEASE AND HOLD HARMLESS Choose2be their officers, officials, agents and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event ("Releases"), WITH RESPECT TO ANY AND ALL INJURY, DISABILITY, DEATH, or loss or damage to person or property, WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEES OR OTHERWISE. I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

Applicant's signature: _____
Date Signed: _____

BODY EVALUATION

Height: _____ Weight: _____
Body measure in inch: Biceps: _____ Shoulder: _____ Waist: _____
Hips: _____ Thigh: _____ Calve: _____
Fat %: _____