THE CHOT ZONE

Health History Questionnaire

ANSWER EACH QUESTION BY PRINTING THE NECESSARY INFORMATION. YOUR ANSWERS ARE CONFIDENTIAL.

Name:	Date of Birth:	Age:
Address:		
City, State, Zip:		
Home Phone:	Work Phone:	
Employer:	Occupation:	
In case of emergency, please notify:		
Name:	Relationship:	
Address:		
City, State, Zip		
Home Phone:	Work Phone:	

MEDICAL INFORMATION

Physician:	Phone:	
Are you under the care of a physician, chiropractor, or other health care professional for any reason? If yes, list reason:	❒ Yes	❒ No
Are you taking any medications? *(If yes, complete the following)* Type: Dosage/Frequency: Reason for Taking:	❒ Yes	❒ No
Please list any allergies:		
Has your doctor ever said your blood pressure was too high?	❒ Yes	❒ No
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	❒ No
Are you over the age of 65?	❒ Yes	❒ No
Are you unaccustomed to vigorous exercise?	❒ Yes	❒ No

Health History Questionnaire

Medical Information, continued

Is there any reason not mentioned why you should not follow a regular exercise program? ❒ Yes ❒ No
If yes, please explain:

Have you recently experienced any chest pain associated with either exercise or stress? ❒ Yes ❒ No
If yes, please explain:

Smoking

Please check the box that describes your current habits:

- ❒ Non-user or former user; Date quit:_____
- ❒ Cigar and/or pipe
- ❒ 15 or less cigarettes per day
- ❒ 16 to 25 cigarettes per day
- ❒ 26 to 35 cigarettes per day
- ❒ More than 35 cigarettes per day

Family and Personal Medical History

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

- ❒ Asthma:_____
- ❒ Respiratory/Pulmonary Conditions:_____
- ❒ Diabetes: Type I:_____ Type II:_____ How Long?_____
- ❒ Epilepsy: Petite Mal:_____ Grand Mal:_____ Other:_____
- ❒ Osteoporosis:_____

Lifestyle and Dietary Factors

Please fill in the information below:

- ❒ Occupational Stress Level: ❒ Low / ❒ Medium / ❒ High
- ❒ Energy Level: ❒ Low / ❒ Medium / ❒ High
- ❒ Caffeine Intake/Daily:_____ ❒ Alcohol Intake/Weekly:_____
- ❒ Colds Per Year:_____ ❒ Anemia:_____
- ❒ Gastrointestinal Disorder:_____
- ❒ Hypoglycemia:_____
- ❒ Thyroid Disorder:_____
- ❒ Pre/Postnatal:_____

Cardiovascular

Please fill in the information below:

- ❒ High Blood Pressure:_____ ❒ Hypertension:_____
- ❒ High Cholesterol:_____
- ❒ Hyperlipidemia:_____
- ❒ Heart Disease:_____
- ❒ Heart Disease:_____
- ❒ Heart Attack:_____ ❒ Stroke:_____
- ❒ Angina:_____ ❒ Gout:_____

Family and Personal Medical History, continued

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/Clavicle:_____
- ❒ Arm/Elbow:_____
- ❒ Wrist/Hand:_____
- ❒ Lower Back:_____
- ❒ Hip/Pelvis:_____
- ❒ Thigh/Knee:_____
- ❒ Arthritis:_____
- ❒ Hernia:_____
- ❒ Surgeries:_____
- ❒ Other:_____

Nutritional Information

Are you on any specific food/diet plan at this time? If yes, please list:	❒ Yes	❒ No
Do you take dietary supplements? If yes, please list:	❒ Yes	❒ No
Do you experience any frequent weight fluctuations?	❒ Yes	❒ No
Have you experienced a recent weight gain or loss? If yes, list change: Over how long?	❒ Yes	❒ No
How many beverages do you consume per day that contain caffeine?		
How would you describe your current nutritional habits?		
Other food/nutritional issues you want to include *(food allergies, mealtimes, etc.)*		

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Work And Exercise Habits

Please check the box that best describes your work and exercise Habits.

- ❒ Intense occupational and recreational exertion
- ❒ Moderate occupational and recreational exertion
- ❒ Sedentary occupational and intense recreational exertion
- ❒ Sedentary occupational and moderate recreational exertion
- ❒ Sedentary occupational and light recreational exertion
- ❒ Complete lack of all exertion

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 a week? ❒ Yes ❒ No

Please make any other comments you feel are pertinent to your exercise program.

Please note: possession of this form does not indicate certification status with the ISSA. To confirm active certification status, please call 1.800.892.4772 (1.805.745.8111 international). Information gathered from this form is not shared with ISSA. ISSA is not responsible or liable for the use or incorporation of the information contained in or collected from this form. Always consult your doctor concerning your health, diet, and physical activity.

NAME: _____

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT: _____ WITNESS: _____
or GUARDIAN (for participants under the age of majority)