Registration Form

1. First Name:_____ 2. Family Name:_____
(Include maiden name if applicable)

3. Sex: ☐Female ☐Male 4. Date of Birth: __ __ / __ __ / __ __ 5. Age: _____
mm dd yyyy

6. Address: _____
Apt # - Street and Number City Province Postal Code

7. Phone #: _____ / _____ / _____
Home Work Cell

8. E-mail: _____

9. Occupation :_____

10. Emergency contact: _____ Phone #: _____

11. Who referred you to CHIP? (MD, nurse, hospital, friend, flyer, poster…) _____

12. Name of Family MD: _____ Cardiologist:_____

Endocrinologist: _____ Other: _____

13. Has a doctor ever told you that you have **cardiovascular disease** (stroke, angina, heart attack, or coronary bypass surgery, angioplasty)? ☐YES ☐NO

14. Has anyone in your immediate family (parents, siblings) developed cardiovascular disease **before age 60**? ☐DON'T KNOW ☐YES ☐NO

15. Does anyone in your immediate family (parents, siblings) have **diabetes**? ☐DON'T KNOW ☐YES ☐NO

16. Do you currently **smoke** one or more cigarettes daily? ☐YES ☐NO

17. Please list current **medications**, **natural products,** or **supplements** and please include **dosage**:

_____ _____ _____
_____ _____ _____
_____ _____ _____

18. **Personal History** (Please check)

Heart condition	_____	Bone or joint problems	_____
High cholesterol	_____	Varicose veins	_____
Diabetes or		High blood pressure	_____
High Blood Sugar	_____	Injuries to back	_____
Epilepsy	_____	Gout	_____
Stroke	_____	Lung disease	_____

Please continue on back

Registration Form

19. **Present symptom review** (Have you recently had any of the following symptoms at rest, during exertion or after exertion?)

Chest pain or discomfort	_____	Lightheadedness or fainting	_____
Back pain	_____	Shortness of breath	_____
Arthritis/swollen joints	_____	Heart palpitations	_____
Recent Illness	_____	Cough on exertion	_____
		Other _____	

20. Do you have problems falling asleep, staying asleep, or waking earlier than planned? ☐YES ☐NO

21. Do you have difficulty with time management and prioritizing? ☐YES ☐NO

22. Are you experiencing difficulty managing your eating habits? ☐YES ☐NO

23. Do you have doubts about your ability to persist with an exercise program? ☐YES ☐NO

24. During the last 7 days, on how many days did you do moderate physical activities for a period of at least 10 minutes, such as brisk walking, carrying light loads, bicycling or swimming at a regular pace, doubles tennis, raking or picking up leaves, or sweeping floors?

_____ days/week

25. How much time did you usually spend doing moderate physical activities on one of those days?

_____ minutes/day

26. During the last 7 days, on how many days did you do vigorous physical activities for a period of at least 10 minutes, such as heavy lifting, digging, aerobics, fast bicycling or swimming, jogging, or playing soccer?

_____ days/week

27. How much time did you usually spend doing vigorous physical activities on one of those days?

_____ minutes/day

28. Do you have any orthopedic problems which could be worsened with exercise?

If yes, please explain: _____

29. Do you have private insurance, who is your provider? _____

Patient Signature: _____ Date: _____/_____/_____
mm dd yyyy