Information Form

Date:____________________

General Information

Name: ________________________ Address: ____________________ Birthdate: _____________

City: _________________________ State: ___________ Zip: ___________ Sex: ___________

Email: ____

Phones (circle the best number to reach you)

Home: _________________ Business: ____________________ Cell: _______________________

Occupation: ______________________________ Referred by: _____________________________

In case of emergency, call: Name: ________________________ Phone: _____________________

Relationship: ____

Personal Physician:

Name: ____

Address: ____

Phone: ____

Health Analysis Circle Yes or No. If yes, please explain

When was your last physical? Date: ____

Are you under a physician's care now? Yes No Explain ____________________________

Are you taking a physician prescribed or over the counter medication? Yes No Explain ____________________________

Do you want me to coordinate your exercise program with a physician? Yes No Explain ____________________________

Name: ____

Address: ____

Phone: ____

Have you had any recent major illnesses? Yes No Explain ____________________________

Have you had a major or minor (outpatient) surgery in the last 5 years? Yes No Explain ____________________________

Do you have or have you ever had high or low blood pressure? Yes No Explain ____________________________

Do you or any of your family have any history of aneurysms or sudden cardiac deaths? Yes No Explain ____________________________

Are you under a physician's care, special diet, or medication?	Yes	No	Explain ______________________________
Do you experience frequent headaches?	Yes	No	Explain ______________________________
Do you have diabetes?	Yes	No	Explain ______________________________
Do you have low back or neck pain, tension or fatigue?	Yes	No	Explain ______________________________
Do you have any joint pain (shoulders, elbow, wrists, hips, ankles, etc.)?	Yes	No	Explain ______________________________
Are you aware of any abdominal hernias, or have you had one repaired in the past?	Yes	No	Explain ______________________________

Can you think of anything to add which I might need to know in order to keep your exercise sessions safe and productive? ____

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Exercise Goals and Concerns

What exercise and/or recreational activities are you engaged in currently? ________________________

____

How would you rate your current level of physical fitness? ______________________________________

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The above statements are true and complete to the best of my knowledge, and hereby authorize Alive! Fitness Studio, Inc. to release information to my physician, or to request from my physician any pertinent information regarding any physical condition that I have indicated above.

Signed: ____ Date: ______________________________