Information Form

Date: _____

General Information

Name: _____ Birth Date: ___/___/_____Sex: _____

Address: _____

City: _____ State: ____ Zip: _____

Email (the one most certain to reach you): _____

Referred by: _____

I would like to receive Alive's email newsletter on topics related to wellness and healthy aging, from which I can un-subscribe at any time. Yes ☐ No ☐

Phones (*circle the best number to reach you*)

Home: _____ Business: _____ Cell: _____

In case of emergency, call: Name: _____
Phone: _____ Relationship: _____

Choose how you wish to receive our notifications: ☐ Email only
☐ Text to your cell phone: Carrier Name _____
☐ Both a text AND an email - Carrier Name_____

Personal Physician:

Name: _____

Address: _____

Phone: _____

Health Analysis: Circle Yes or No, below 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: _____Phone: _____

Address: _____

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? _____

_____

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? _____

_____

The above statements are true and complete to the best of my knowledge, and hereby authorize Alive! Fitness Studio LLC 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: _____