

WELLNESS INFORMATION FORM

Full Name: _____

Day Time Phone#: _____ Height: _____ Weight: _____

Gender: _____ Age: _____ Date of Birth: _____

In case of emergency (please contact)

Name: _____ Phone Number: _____

Relationship: _____

Confidential Medical History

1. Date of most recent medical examination: _____

2. Do you feel fine- without restrictions? Yes: _____ No: _____

3. Have you ever been hospitalized or treated for an injury? Yes: _____ No: _____

If yes, please describe: _____

4. Have you ever been injured and not received medical attention? Yes: _____ No: _____

If yes, please describe: _____

5. Do you have any current medical conditions (please include pregnancies) for which you are currently being treated? Yes: _____ No: _____ If yes, Please describe: _____

6. Are you currently using any prescription drugs? Yes: _____ No: _____

If yes, please describe: _____

7. Circle if you have: Allergies Difficulty Breathing High Blood Pressure Diabetes

If yes, please describe: _____

8. How Frequently do you exercise: _____

What type of exercise? _____

9. Are you or have you ever been involved in self-defense or Martial Arts Training? Yes: _____ No: _____

10. Please describe you perception of you current fitness level?

The above information is complete, true and accurate to the best of my knowledge.

Signature

Instructor check