

Appointment	_____	_____
	Date	Time
Instructor	_____	

Date ____/____/____

Member Information:

Name:		
Address:		
City:	State:	Zip:
Nickname:		
Date of Birth:	Weight:	Gender:
Primary Phone:	Other Phone:	
E-mail:	Company Name:	

Please select a 5 digit Facility ID #: 1st Choice _____ **2nd Choice:** _____
(must begin with the Number 2)

Exercise Information: Circle Yes or No

1. Are you over age 65 and not accustomed to vigorous exercise?	Yes	No
2. Do you frequently have pain in your heart or chest?	Yes	No
3. Do you often feel faint or have spells of severe dizziness?	Yes	No
4. Has your doctor ever said that your blood pressure was too high?	Yes	No
5. Has your doctor ever told you that you have a bone or joint problem?	Yes	No
6. Has your doctor ever said that you have heart trouble?	Yes	No
7. Is there a good physical reason not mentioned here that you should not follow an activity program even if you wanted to?	Yes	No

WORK OUT TYPES	MEDICAL HISTORY	MEDICATIONS
<input type="checkbox"/> LOSE WEIGHT	CARDIOVASCULAR	
<input type="checkbox"/> TONE	<input type="checkbox"/> Coronary Bypass	
<input type="checkbox"/> GAIN WEIGHT	<input type="checkbox"/> Current Heart Murmur	
<input type="checkbox"/> BULK	<input type="checkbox"/> Heart Attack	
<input type="checkbox"/> OTHER (please explain below)	<input type="checkbox"/> High Blood Pressure	
	<input type="checkbox"/> High Cholesterol	
	<input type="checkbox"/> Other	
	MUSCULOSKELETAL	
	<input type="checkbox"/> Joint Swelling _____	
	<input type="checkbox"/> Broken Bones _____	
	<input type="checkbox"/> Knee Problems	
	<input type="checkbox"/> Shoulder Problems	
	<input type="checkbox"/> Neck Problems	
	<input type="checkbox"/> Back Problems	
	<input type="checkbox"/> Other	
	PULMONARY	
	<input type="checkbox"/> Allergies	
	<input type="checkbox"/> Asthma (exercise induced)	
	<input type="checkbox"/> Chronic Recurring cough	
	<input type="checkbox"/> Other	

