

WELLNESS INFORMATION FORM

	×		
Phone	e:Height	Weight	
der:	Age: Date of Birth:		
ase of e	emergency (please contact)		
Nai	me:		
	one:		
Rel	lationship:		
	Confidential Medical History	¥	
1.	Date of Most Recent Medical Examination:		
2.	Do you feel fine – Without Restrictions? YesNo		
Ifn	no, Please Describe:		
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 in	medical attention?	
	Yes No	nedical attention.	
	If yes, please describe:		
	Do you have any current medical conditions (Please include pre		
	cies) for which you are currently being treated?		
	Yes No If yes, please desc	cribe:	
6.	Are you currently using any prescription drugs? Yes No		
•	If yes, please describe:		
7.	Do you have: Any known Allergies?	Yes No	

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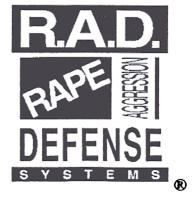
		Training? Yes No If yes, please describe:
	9.	Are you or have you ever been involved in self-defense or Martial Arts
	8.	How frequently do you exercise?
		If yes, please describe:
TEMS R		Diabetes? Yes No
FNSF		High Blood Pressure? Yes No
AGGER		Difficulty Breathing? Yes No

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

10. Please describe your perception of your current fitness level.

Signature

Instructor Check



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