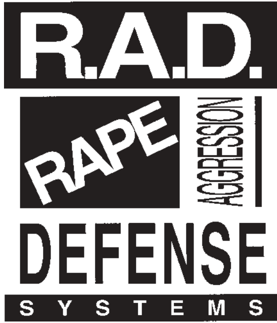

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WELLNESS INFORMATION FORM

Full Name: ____

Day Phone: _______________ Height _________ Weight _________

Gender: _______ Age: __________ Date of Birth: ____________

In case of emergency (please contact)

Name: ____

Phone: ____

Relationship: ____

Confidential Medical History

1. Date of Most Recent Medical Examination: ______________
2. Do you feel fine – Without Restrictions? Yes _____ No ____

If 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 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. Do you have: Any known Allergies? Yes ____ No ____

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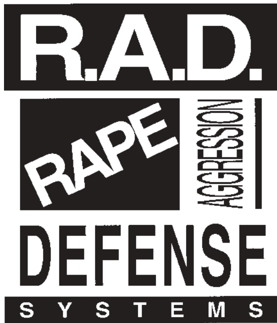
(225) 791-4430



Difficulty Breathing? Yes ____ No ____

High Blood Pressure? Yes ____ No ____

Diabetes? Yes ____ No ____

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 ________

   If yes, please describe: ______________________________

   ____

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

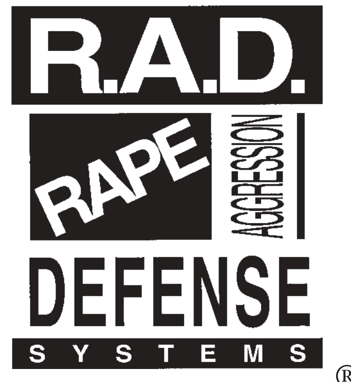
The above information is complete, true and accurate to the best of my knowledge.

____

Signature

____

Instructor Check



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