

Date \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

E-mail \_\_\_\_\_ D.O.B. \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

(1) Are you currently taking any medication? • Yes • No

Type \_\_\_\_\_ Reason \_\_\_\_\_

Type \_\_\_\_\_ Reason \_\_\_\_\_

Type \_\_\_\_\_ Reason \_\_\_\_\_

Type \_\_\_\_\_ Reason \_\_\_\_\_

(2) Do you have or have you ever had any of the following conditions?

CONDITION		DESCRIPTION
Heart Attack	• Yes • No	_____
Stroke	• Yes • No	_____
Chest pain	• Yes • No	_____
Hypertension	• Yes • No	_____
Diabetes	• Yes • No	_____
Cancer	• Yes • No	_____
High Cholesterol	• Yes • No	_____
Hernia	• Yes • No	_____
Arthritis	• Yes • No	_____
Thyroid	• Yes • No	_____
Anemia	• Yes • No	_____
Respiratory	• Yes • No	_____
Other	• Yes • No	_____

(3) Have you ever been injured in any of the following areas?

BODY PART		DESCRIPTION	WHEN?
Head / Neck	• Yes • No	_____	_____
Shoulders	• Yes • No	_____	_____
Chest	• Yes • No	_____	_____
Arms	• Yes • No	_____	_____
Abdomen	• Yes • No	_____	_____
Back	• Yes • No	_____	_____
Legs / Feet	• Yes • No	_____	_____

(4) Are you currently under the care of a physician for any reason at all?

• Yes • No If Yes, explain \_\_\_\_\_

(5) Do you smoke? • Yes • No If Yes, how much? \_\_\_\_\_

(6) Do you know of any physical condition that you have had or currently have that could be aggravated by exercising or exerting yourself?  
If Yes, explain \_\_\_\_\_

(7) Are you taking any medication which could cause a reaction while exercising?  
• Yes • No If Yes, explain \_\_\_\_\_

(8) Does your physician know that you are beginning a new exercise program? • Yes • No

(9) Does your physician object to you beginning a new exercise program?  
• Yes • No If Yes, explain \_\_\_\_\_

**RELEASE**

I know of no physical or medical condition which I, or my physician, feel could be aggravated by my using the equipment of St Francis Sports Medicine or with Fitness In Training staff. I agree to advise Tony Estes in writing if any of the above information changes or if my physician advises me to stop, reduce, or otherwise adjust my exercise regimen. I will advise Tony Estes and St Francis Sports Medicine immediately if I injure myself in any way while on premises. I assume all risks of injury and agree to hold harmless and waive any claim or rights that I might have to hold liable Tony Estes, Fitness In Training and St Francis Sports Medicine employees, owners, officers, or any agents. The information I have listed on this form is, to the best of my knowledge, complete and accurate. I understand that I am responsible for the full cost of each session unless I give Tony Estes at minimum twenty four hours notice of cancellation of any scheduled appointment.

Signature \_\_\_\_\_

Date \_\_\_\_\_