

Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (H) _____ (W) _____
E-mail: _____

To help us meet your needs and guide you in the right direction, please complete each question accurately. All information provided is confidential.

Emergency contact: _____ Phone #: _____
Relationship: _____ Alt. Phone#: _____

Medical History

Have you been diagnosed or currently treated by a physician or health professional for: (please circle)

High blood pressure High Cholesterol Diabetes Heart Problem
Epilepsy Arthritis (Osteoarthritis, Rheumatoid, Etc.) Asthma Emphysema
Other: _____

Are you currently taking any medications or dietary supplements? **Yes** **No**

If you checked "yes" please list medication, dosage, and for what condition.

Medication / Supplement

Have you had surgery in the last 6 months? **Yes** **No**

If yes, please explain. _____

Do you have a history of any injuries or areas of consistent discomfort? **Yes** **No**

If yes, please explain. _____

Are you currently undergoing treatment from any of the following?

Physical Therapist _____ Chiropractor _____ Massage Therapist _____

If yes, why? _____

Fitness Information

What is your current exercise level?

None _____ 2-3 times per week _____ 4-5 times per week _____

What type? _____

Do you include stretching into your current workout? **Yes** **No** If so, how often? _____

Goals

Please list your goals & reasons participating in our programs at EVOLUTION: