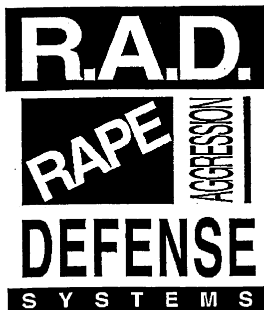

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CONFIDENTIAL WELLNESS INFORMATION FORM
(For Emergency Purposes Only)

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: ___________
   ____

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6. Are you currently using any prescription drugs? Yes ___ No___
   If yes, please describe: ________________________________
   ____

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