

®

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: _____

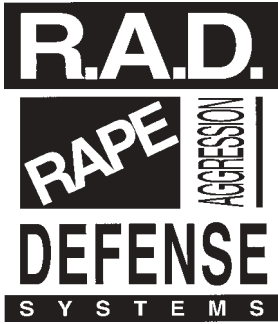
5. Do you have any current medical conditions (Please include pregnancies) for which you are currently being treated?

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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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: _____

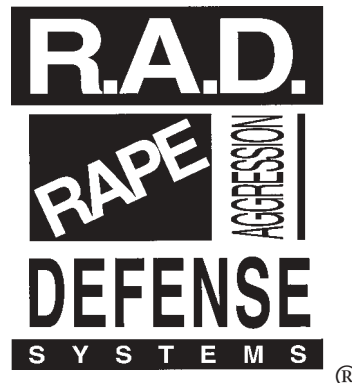
10. Please describe your perception of your current fitness level.

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

Signature

Instructor Check

R.A.D. SYSTEMS
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