# CLIENT SIGN-UP INFORMATION

Name: _____ Date: _____

Date of Birth: M _____D _____Y_____ Gender associated with: Male / Female / Other

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Work: _____ Mobile: _____

E-Mail Address: _____

Emergency Contact: _____ Phone: _____

Physician's Name: _____ Physician's Phone: _____

How did you find out about us? / Referred by: _____

Describe your current physical activity and exercise program _____

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Describe any previous exercise routines, or other Functional Movement Programs you have participated in

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We encourage you to consult with your physician before beginning a new exercise program. Does your Doctor know that you are taking this exercise program? Yes No

What is your primary goal with beginning a fitness regimen at Wellosophy360 Studio?

□ Increase Strength □ Increase Flexibility □ Decrease Stress
□ Weight Loss □ Injury Rehab □ Increase Range of Motion

□ Other (describe): _____

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## Health History

Do you have any of the following conditions?

□ Heart Condition □ Cancer □ Diabetes
□ Chest pain □ High Blood pressure □ Epilepsy
□ Migraines □ Asthma □ Hernia/Hiatus Hernia
□ Low back pain □ Neck Pain □ Joint Pain
□ Arthritis (type & location?) _____
□ Other, please specify: _____
(Please use reverse side to elaborate on any conditions checked "yes")

Have you had surgery in the last 12 months? YES / NO Date: _____

If yes, please describe: _____

Will you consult your physician prior to training YES / NO. If not, do you waive liability YES / NO.

**Name:** _____**Signed** _____ **Date** _____

Please Note: If your health changes such that you would need answer "yes" to any of the above questions, tell your fitness or health professional, as well as your doctor.

Those clients under 18 years of age must have this form signed by a parent or guardian.