

Please print, complete and return at your first scheduled session.

All information received on this form will be treated as strictly confidential.

Please fill out the forms **completely and accurately**. This information is essential to helping your trainer develop a program that addresses your needs, goals, and is safe and effective.

Address: Street City State Zip Code Phone:	Name:	_ Date of Birth	1/////	
Phone:	Address:			
Email address: Occupation: Emergency Contact: Relationship: Phone Number: Physician's Name: Physician's Phone: Physician's Address:		City	State	Zip Code
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Physician's Address:	Phone Number:			
	Physician's Name:	Physicia	an's Phone:	
Street City State Zip Code	Physician's Address:			
	Street	City	State	Zip Code