Name:

Membership Application

Thank you for your interest in AthletEdge. Please complete the application and return it to us promptly for review (Please Print or Type).

Participation in any of AthletEdge programs is prohibited until you complete the following steps:

1. Complete and return this application
2. Complete Health History Questionairre
3. Complete and Sign the PAR Q
4. Complete and Sign Waiver and Release
5. Complete and Sign Release of Multimedia

Date: _____

Name: _____ Phone: _____

Address: _____ Cell: _____

City: _____ State: _____ Zip: _____

Email Address: _____

DOB: _____ Age: _____ Gender: Male: _____ Female _____

Height: _____ Feet/Inches Weight: _____ Pounds

Sport Concentration, if applicable: _____ Position: _____

School/College/Team: _____ City/State: _____

Coach: _____ Phone: _____

Employer: _____ Occupation: _____

Who to contact in case of Emergency:

Primary Contact: _____ Relationship: _____

Phone: _____ 2nd Phone: _____

Secondary Contact: _____ Phone: _____

Physician: _____ Physician Phone: _____

I attest to my knowledge that the answers in this application are valid and true. I understand the nature of AthletEdge's exercise programming, as well as the benefits and the risks involved. I understand that my participation is voluntary and that I may withdraw at any time.

Printed Name of Participant	Signature of Participant	Date

Signature of Parent or Legal Guardian (if < 18)	Date

Printed Name of Parent(s)/Legal Guardians	Home Phone	Cell Phone

Name: _____

Health History & Questionnaire

Physician:	Phone:
When was your last physical exam? _____	

Are you under the care of a physician, chiropractor, or other health care professional for any reason? □ YES □ NO

If yes, list reason:

Are you taking any medications? □ YES □ NO

If yes, complete the following:

Type	Dosage	Frequency	Reason for Taking

List any allergies (ie. Foods, medications, or other substances):

Medications	Other Substances	Foods

Cardiovascular Risk

	You	Mother	Father	Grandparents
High Blood Pressure	□	□	□	□
High Cholesterol	□	□	□	□
Diabetes	□	□	□	□
Heart Disease	□	□	□	□
Bypass Surgery	□	□	□	□
Stroke	□	□	□	□

Indicate any problems you may have had or currently have:

□ Asthma
□ Shortness of Breath
□ Seasonal Allergies
□ Sinus Problems
□ Fatigue
□ Chronic Pain
□ Ulcers
□ Varicose Veins
□ Hemmorroids
□ Rheumatic Fever
□ Mononucleosis
□ Eating Disorders
□ Back Injury
□ Joint Pain
□ Swollen, Stiff, or Painful Joints
□ Nerve Entrapment (ie. Carpal Tunnels)
□ Joint Injury
□ Broken Bones
□ Muscle Sprains / Strains
□ Arthritis
□ Bursitis
□ Blackouts / Loss of Consciousness
□ Unexplained dizziness / fainting
□ Skin Problems (rashes, itching, acne)
□ Hernia
□ Low Blood Pressure
□ High Blood Pressure
□ Diabetes
□ Thyroid Problems
□ Epilepsy
□ Anxiety
□ Depression
□ Nervous Tension
□ Hepatitis
□ Heat Cramps / Exhaustion
□ Seizures

Name: _____

Health History & Questionnaire

Are you pregnant or is it likely that you could be pregnant at this time? □ YES □ NO □ N/A

First menstrual cycle began at what age? _____ □ N/A

When was the last day of previous menstrual cycle? _____ □ N/A

What is the longest time between menstrual cycles? _____ □ N/A

How long do your menstrual cycles last? _____ □ N/A

How would you rate your stress level from 1-10 (10-highest)? _____

How many hours of sleep do you get each night? _____

Is the quality of your sleep: □ good □ fair □ poor

Do you smoke? □ YES □ NO If yes, how much per week? _____

Do you consume alcohol? □ YES □ NO If yes, how much per week? _____

Are you now or have you ever taken recreational drugs? □ YES □ NO

Have you ever used performance enhancing substances? □ YES □ NO

□ If yes, what sustances have you used?

1 _____

2 _____

3 _____

4 _____

5 _____

Have you ever used anabolic steroids or derivatives? □ YES □ NO

Are you involved in any sporting activity? □ YES □ NO

□ If yes, what sporting activity? _____

How long have you been involved in your sport? _____ years

Do you participate in a regular physical activity or exercise program? □ YES □ NO

type: _____

I have been training consistently for: _____ *weeks* *months* *years*

Frequency: _____ days per week

Average duration: _____ minutes

Intensity: *low* *moderate* *high*

Is your motivation for training? *poor* *ok* *good* *excellent*

What are your goals for training? Please be specific.

How often do you eat each day? _____

How many times do you eat out each week (including junk food)? _____

Does your diet change on the weekends? □ YES □ NO

Do you eat with your family? □ YES □ NO

Do you take nutritional supplements? □ YES □ NO

If yes, what supplements are you taking?

1 _____

2 _____

3 _____

Do you fade or tire near the end of your training or competition? □ YES □ NO

Do you get lightheaded and/or have energy slumps or slow reaction times? □ YES □ NO

Do you lose more than 3% of your body weight during training sessions? □ YES □ NO

Do you often feel overly fatigued, tired, cranky, and irritable, and/or suffer from a lack of motivation to train or compete? □ YES □ NO

Do you feel you eat a well rounded nutritious diet? □ YES □ NO

Name:

Health History & Questionnaire

I certify that to the best of my knowledge, all of the information herein is true and complete. I understand that a medical history is a very important factor in the development of my fitness/exercise program. I understand that certain medical or physical conditions which are known to me, but that I choose not to disclose to AthletEdge may result in serious injury, and possibly death. If my health or status changes, I will notify AthletEdge immediately as well as immediately stop the exercise program and seek medical attention. I knowingly and willingly assume all risks of injury resulting from my failure to disclose accurate, complete, and updated information in accordance with this health history and questionnaire.

I grant permission for AthletEdge to use my information from the health history and questionnaire at their discretion for the purposes of research and marketing with the child's identity protected at all times. I also give permission for AthletEdge, their respective administrators, directors, agents, officers, volunteers, contractors, and employees to evaluate this information and forward it to any medical personnel deemed necessary by AthletEdge.

I understand the nature of AthletEdge's exercise programming, as well as the benefits and the risks involved. I understand that my particiapation is voluntary and that I may withdraw at any time.

Printed Name of Participant	Signature of Participant	Date

Signature of Parent or Legal Guardian (if participant is less than 18 yrs of age)	Date

Printed Name of Parent(s)/Legal Guardians	Home Phone	Cell Phone