



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: _____



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

