THRIVE FITNESS, LLC and BodySoulandPole

Registration Form: Initial Consultation

Name: ___________________________ Age: _________________ M/F ________ DOB__________

Address: ____

Email address: ____

Best Phone Number to reach you: ____

Occupation_____________________________(Need to know if you are at a desk or on your feet)

1. Are you currently exercising? ______________________

If yes, what type of exercise? ____

2. What is your goal?

Weight Loss	Overall Healthy Aging	Mental Clarity
Energy and Performance	Build Lean Muscle	Fun

3. How would you rate your energy from 1-10? _______________________

4. Do you take any vitamins, supplements, etc. currently? What are they?

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5. What is your current weight? ___________ Height? __________

6. What is your ideal weight? ___________

7. Do you have a healthy diet? ____________

8. Do you smoke? **Yes** **No**

9. Do you have a family history of medical conditions? Yes No (if yes, please list)

10. Do you have any injuries or history of injuries? Including sprains, etc. Initial _________

11. Have you suffered from or been diagnosed with any of the following:

High blood pressure	Breathing difficulties
Pulmonary disease	Vascular disease
Cancer	Recent Illness
Seizures	Diabetes
Allergies	Tremors
Hernia	Back/neck pain
Joint condition/injury	Soft tissue injury
Ankle edema	Unusual fatigue
High cholesterol	High HDL cholesterol

Has your doctor ever said you have a heart condition and that you should only do physical activity recommended by your doctor? **Yes No**

Are you pregnant or think you may be pregnant? **Yes No**

Do you know of any other reason why you should not do physical activity? **Yes No**

Are you taking any medications? **Yes No**
Please list____

If my health should change so that I could answer YES to any of the above questions, I (print name) ______________________________________, am responsible for informing my instructor and management at Thrive Fitness/BSP. By signing this form and the liability waiver, I state all answers are of truth.

Signature____Date__________________________

Family Physican____

Physician's phone____

In case of an emergency please call

______________________________Relationship_________________ Phone___________________

Witness Signature ____ Date _____________________

How did you hear about us?

Member: _____________________________________ Other: ______________________________