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 your are currently being treated?
   Yes_____No_____
   If yes, please describe:

6. Are 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: