

®

WELLNESS INFORMATION FORM

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: _____

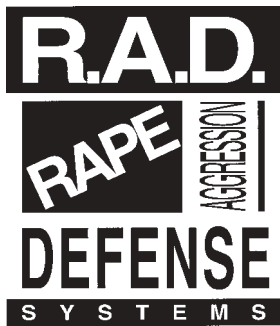
5. Do you have any current medical conditions (Please include pregnancies) for which you are currently being treated?

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: _____

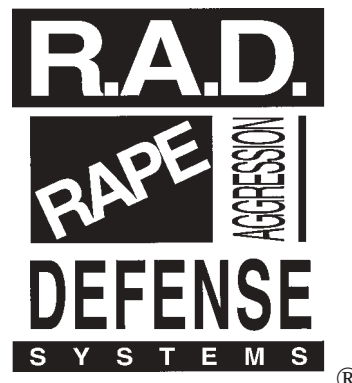
10. Please describe your perception of your current fitness level.

The above information is complete, true and accurate to the best of my knowledge.

Signature

Instructor Check

R.A.D. SYSTEMS
23305 HWY 16
DENHAM SPRINGS, LA 70726
(225) 791-4430



®