Whirling Thunder Wellness Program
Personal Training

NAME: ______________________________ DATE: ______/______/______

ADDRESS: ____

CITY: ______________________ STATE: ________ ZIP CODE: ____________

HOME PHONE: (______) ______________________ CELL PHONE: (______) ______________________

EMAIL: ____

SEX: ____M ____F AGE: __________ BIRTHDATE: ______/______/______

MEDICAL HISTORY:

Circle all that apply to indicate if you have or had any of the following:

Asthma	High Cholesterol	Seizures	Diabetes	Stroke
Psychiatric care	Headaches	Cancer	High Blood Pressure	Low Blood Pressure
Sinus Problems	Ear Problems	Arthritis	Seasonal Allergies	Tonsillitis
Kidney	Bladder Problem	Ulcers / Colitis	Depression	Neurological Problem
Swollen ankles	Anxiety	Heartburn / Reflux	Thyroid Problems	Shortness of Breath
Anemia	Blood Problems	Heart Disease	Murmur / Angina	Lung Problems
Cough	Liver Problems	Eye Disorder	Glaucoma	

What goals are most important to you?____

____

What is currently keeping you from achieving your goal (s)? ______________________________

____

Would you be interested in workouts with a group? ______Y______N

What time best suits you? _____MORNINGS ____ AFTERNOONS ____EVENINGS

What days work best for you? _____S_____M_____T_____W_____T_____F_____S

In Case of Emergency, CONTACT:

NAME: ______________________________ RELATIONSHIP: ______________________________

CELL PHONE: (______)______________________ WORK PHONE: (______)______________________