



Printed Registration Form

1. Print this form; fill in your information clearly and completely
2. Choose the method to return your forms
By Mail: P.O. Box 43141
Jacksonville, FL 32203

I would like to sign up for Group Fitness/Wellness Program: _____
(Write number of participants here)

Name of Organization: _____

Contact Name: _____ Title/Position: _____

Address:

Street Address

City

State/Zip

Business Phone: _____

Alternate Phone: _____

Email: _____

Average fitness level of participants _____ (use scale of 1-10, 10 being highest = elite athlete)

Our Group Fitness/Wellness Program main goal is:

How did you hear about Abdominal Training Wheels, Inc.?

If by Referral please provide their name: _____

MEDICAL HISTORY QUESTIONNAIRE*

All "YES" answers require a written explanation on the next page

QUESTIONS

	YES	NO
1. Are you allergic to any medication (aspirin, penicillin, sulfa, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you take any prescribed medication on a permanent or semi-permanent basis?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have a seizure disorder (epilepsy)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have diabetes: Type I or Type II?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever been found to be anemic (low blood count)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have High Blood Pressure (hypertension)?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have or have you ever had Heart Disease?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have or have you ever had Lung Disease?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have or have you ever had Kidney Disease?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have or have you ever had Liver Disease?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have or have you ever had asthma?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have or have you ever had severe neck injury?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever been knocked out?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you had a broken bone or fracture in the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever injured your back?	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you have back pain? If YES, circle the best answer below	<input type="checkbox"/>	<input type="checkbox"/>
Almost Never Seldom Occasionally Frequently with vigorous exercise or heavy lifting		
18. Have you had knee pain in the past 2 years that has disabled you for longer than a week?	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have other physical conditions, which cause pain?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you had any surgical procedures?	<input type="checkbox"/>	<input type="checkbox"/>
21. Are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you ever had your body fat tested?	<input type="checkbox"/>	<input type="checkbox"/>
23. Are you training for a specific event?	<input type="checkbox"/>	<input type="checkbox"/>

If you are unsure about the definition of any terms in this form, please call us to clarify. Do not assume.

24. What are your goals for the next three months?

PLEASE EXPLAIN ALL "YES" ANSWERS BELOW. PLEASE REFERENCE THE QUESTION NUMBER.

*Each participant must be asked these questions. Write in the above allotted space; the name, medical condition and explanation (If necessary please attach a separate sheet. Our goal is to be safe at all times.)

NOTICE: It is wise to seek your doctor's advice BEFORE beginning any health/fitness/nutrition program!