

Delphos Safety City
WELLNESS INFORMATION FORM



Full Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Day Phone: _____ Height: _____ Weight: _____
Gender: _____ Age: _____ Date of Birth: _____
Eye Color: _____ T-Shirt Size: _____

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 restriction? 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 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?

9. What type of exercise?

10. Are you or have you ever been involved in self-defense or Martial Arts

Training? Yes _____ No _____

If yes, please describe: _____

11. Please describe your perception of your current fitness level:

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

Signature

Instructors Check

