

# BOYNTON BEACH FITNESS BOOT CAMP

NAME: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE: (home) \_\_\_\_\_ (cell) \_\_\_\_\_

**Primary Contact:** (Circle one) Home or Cell

In case Boot Camp has to be moved due to weather.

EMAIL ADDRESS: \_\_\_\_\_

You'll receive our bi-monthly newsletter. Your email address will never be sold or given away.

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SEX: \_\_\_\_\_ (M or F) HEIGHT: \_\_\_\_\_ (in.)

CURRENT WEIGHT: \_\_\_\_\_ (lbs) DESIRED WEIGHT: \_\_\_\_\_ (lbs)

PRIMARY GOAL : \_\_\_ Lose Weight \_\_\_ Maintain Weight \_\_\_ Gain Weight \_\_\_ Tone Up

How did you hear about us? \_\_\_\_\_

# BOYNTON BOOT CAMP

## MEDICAL HISTORY:

- |   |   |   |
|---|---|---|
| Y | N | Have you experienced any of the following?                                      |
| Y | N | Heart attack, coronary bypass or other coronary surgery?                        |
| Y | N | Chest discomfort (especially with exertion)?                                    |
| Y | N | High blood pressure?  |
| Y | N | Extra, skipped or rapid heart beats/palpitations?                               |
| Y | N | Heart murmurs, clicks, or unusual cardiac findings?                             |
| Y | N | Rheumatic fever?  |
| Y | N | Ankle swelling?   |
| Y | N | Peripheral vascular disease?  |
| Y | N | Phlebitis, emboli?  |
| Y | N | Unusual shortness of breath?  |
| Y | N | Light headedness or fainting?   |
| Y | N | Pulmonary disease (e.g., asthma, emphysema and bronchitis)?                     |
| Y | N | Abnormal blood lipids (cholesterol, triglycerides)?                             |
| Y | N | Stroke?   |
| Y | N | Recent illness, hospitalization or surgical procedure within the past 4 months? |
| Y | N | Medications of any kind? (if yes, list all on back)                             |
| Y | N | Diabetes or other metabolic disorders?  |
| Y | N | Are you pregnant now?   |
| Y | N | Is there any reason your physician would object to your dieting?                |
| Y | N | Is there a history of heart disease in your family?                             |
| Y | N | Is there any reason your physician would object to your exercising?             |

Signature \_\_\_\_\_ Date \_\_\_\_\_