ATHLETE INFORMATION

Last Name: ____________________________ First Name: ______________________ M.I: _________

Birthday: _______/_______/_______ Gender: M or F Height: _______ Weight: _________

Address: _________________________________ City: ________________ State: _____ Zip: ___________

Home Phone: (______)___________________ E-mail Address: _____________________________________

School: ____ Grade: ____________________________

Have you ever trained with us? When? ____

EMERGENCY CONTACT: _____________________________ EMERGENCY Ph # : (_____)_______________

Fathers Full Name:___________________________ Address (if different) : _______________________________

Mothers Full Name:___________________________ Address (if different) : _______________________________

MEDICAL INFORMATION / RISKS: ____

	Sport #1	Sport #2	Sport #3	Sport #4
School/Club Name				
Sport				
Level (V, JV, U15)				
Position				
Coach				

FOR OFFICE USE ONLY

Level / Program: ___________________________ Start Date: _____________ Stop Date: _______________

	Date	Red	Date	Green	Date	Yellow	Date	Purple	Date	Orange	Date
PRE		#1		#1		#1		#1		#1	
WTS 1		#2		#2		#2		#2		#2	
WTS 2		#3		#3		#3		#3		#3	
POST		#4		#4		#4		#4		#4	
		#5		#5		#5		#5		#5	
		#6		#6		#6		#6		#6	
Free Trail		#7		#7		#7		#7		#7	

Payment Information:

Cost of Program: $_______________	**Membership Paid:** $____________	**Amount Paid:** $____________	**Payment Date:** (Trainer Initials)___________	**Discount:** %______
Type of Payment: CASH CHECK CC (please circle one)	**Wts ID:**	**Wts Roster:**		

TOTAL PERFORMANCE Training Center

CLIENT PROFILE

Name ________________________________ Age____________ Date______

Are you currently under the care of a physician? Yes No

Would you like your trainer to contact your physician? Yes No

If Yes: Doctor __________________________ Phone # (_______)_______________

Are you currently taking any medications? Yes No

If yes, what?____

	Yes	NO		Yes	NO
Asthma, bronchitis or other respiratory problems	____	____	Arthritis	____	____
High blood pressure	____	____	Shortness of breath	____	____
Heart disease	____	____	Chest pains	____	____
Diabetes	____	____	Dizziness	____	____
Irregular heart rate	____	____	Major injuries	____	____
Major surgeries	____	____	Smoking	____	____

Please Provide an explanation if answered *Yes* to any of the above if necessary (i.e., typle of surgeries or injuries and/or other medical risks not specified. ____

____

____

Has anyone in your family ever been diagnosed with any of the above conditions? Yes No

If yes, please explain ____

____

Do you have any other disabilities that might affect your training program? Yes No

If yes, please explain ____

____

Is there any other reason, NOT mentioned previously, why you should not follow an exercise program? Yes No

If yes, please explain ____

____