FOUR WINDS
MARTIAL ARTS ACADEMY

Contact and Billing Information

Name: _____ Date: / /

Date of Birth: / / M F Height: _____ Weight: _____

Address: _____

City State Zip

Email Address: _____

Home Phone: _____ Mobile Phone: _____

Emergency Contact Information

Contact Name: _____ Relation: _____ Phone: _____

Contact Name: _____ Relation: _____ Phone: _____

Health History Information

Physician: _____ Phone: _____

Date of last physical exam by a doctor: / /

List any medications you are currently taking: _____

_____

Are you currently under a physician's care? _____

If yes, for what condition(s)? _____

Have you ever been diagnosed and/or treated, or are you currently experiencing any of the following:

- ☐ Back pain or injury _____
  - ☐ Herniated disc _____
  - ☐ Spinal surgery _____
- ☐ Muscle or tendon surgery _____
- ☐ Joint problem/surgical procedures
  - ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hip
  - ☐ Knee ☐ Ankle ☐ Foot

Explain _____

- ☐ Epilepsy
- ☐ Hypertension
- ☐ Heart condition or angina
- ☐ Chest Pain
- ☐ Arthritis _____
- ☐ Astmha/respiratory condition including exercise-induced asthma
- ☐ Diabetes
- ☐ Any eye condition
- ☐ Hypoglycemia
- ☐ Any neurological condition
- ☐ Polio, scoliosis or other musculoskeletal condition
- ☐ Hernia
- ☐ Any hearing or inner ear condition
- ☐ Lung or chest cavity condition
- ☐ Stroke, brain hemorrhage or any other neurological event

☐ Other (please specify) _____

☐ None of the above

General Student Information

What sports or activities do you participate in, and how often?

Have you trained in martial arts before? If yes, what style and for how long?

What are your martial arts goals?

What are your fitness goals?

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

_____ _____

Signature Date

_____ _____

Witness Date