

SOURCE –

How did you find out about
Boxing Works?



Surname:

First Name: D.O.B. / /

Address:

Suburb: Post Code Male/Female

Phone (m) (W)

Email:

In case of emergency contact:

Phone (m) (W)

MEDICAL HISTORY: Do you suffer from or have you ever suffered from any of the following: Please tick

	YES	NO		YES	NO
HEART CONDITION/CHEST PAINS			Is there any other condition that may restrict physical activity? Details...		
HIGH/LOW BLOOD PRESSURE					
DIABETES			Are you currently on any medication? Details...		
THROMBOSIS / POOR CIRCULATION					
EPILEPSY			Have you had surgery in the last 2 years?Details...		
RHEUMATIC FEVER					
LIVER / KIDNEY CONDITION			Are you pregnant? When was your last medical check up?		
ASTHMA					
ARTHRITIS			Are you currently a smoker? Are you currently exercising? Details...		
MUSCLE / BONE / JOINT PROBLEMS					
CHRONIC BRONCHITIS					
ALCOHOL / DRUG DEPENDENCY					
ANOREXIA / BULIMIA					

Please state what your personal goals and objectives are.

***“Our goal is...
to help you achieve your goals”***

Would you like to receive a newsletter by e-mail? Yes / No (Please circle one)

I hereby certify that I am aware of no medical problem (except those already noted) that may effect my participation in a regular exercise program.

I have read and understood this questionnaire and hereby exempt Boxing Works, its servants, agents and contractors of liability for any injury sustained during, or as a result of my participation in any activity within Boxing Works Centre.

Signature _____ Date _____
Parent or Guardian if under 18 years of age