

***PERSONAL INFORMATION:***

Full Legal Name: \_\_\_\_\_ Birth date: D \_\_\_\_\_ M \_\_\_\_\_ Y \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Occupation: \_\_\_\_\_

Phone: (H): \_\_\_\_\_ Day: \_\_\_\_\_ Employer: \_\_\_\_\_

Email: \_\_\_\_\_

In Case of Emergency, Name: \_\_\_\_\_ Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

***LICENSE INFORMATION:***

Drivers' License Number: \_\_\_\_\_ Class: 1 2 3 4 5 6 Expiry Date: \_\_\_\_\_

License Restriction:  Glasses  Speed  Other \_\_\_\_\_

***MEDICAL INFORMATION:***

**Please indicate any medical condition, physical disability, previous injury, weakness or any other conditions that could affect you during training.**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> NONE                | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Muscle Control    |
| <input type="checkbox"/> Heart Condition     | <input type="checkbox"/> Hearing Impairment    | <input type="checkbox"/> Previous Injuries |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bone or joint problem | <input type="checkbox"/> Epilepsy          |
| <input type="checkbox"/> Pregnancy           | <input type="checkbox"/> Colour Blindness      |  |
| <input type="checkbox"/> Back Problems       | <input type="checkbox"/> Other: _____          |  |

If you are currently under a doctor's care, please specify condition being treated and any medications taken: \_\_\_\_\_

**REFERENCE:**

What skills would you most like to improve?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_