



All information gathered on this form will be kept completely confidential

Name:

Address:

Date of Birth: / / Male / Female

Home phone: Mobile phone: Work phone:

Email:

Emergency contact: Relationship to you:

Home phone: Mobile phone: Work phone:

Doctor: Practice name:

Phone:

Medical Conditions

Have you or an immediate family member ever had any of the following? *(Please circle)*

Heart disease/chest pain YES / NO

Stroke YES / NO

Raised cholesterol YES / NO

High/Low blood pressure YES / NO

Diabetes YES / NO

If yes please circle which one: Type 1 Type 2 Gestational

Do you have any of the following?

Asthma YES / NO

Epilepsy YES / NO

Hernia YES / NO

Are you pregnant? YES / NO

Have you recently been pregnant? YES / NO

Do you smoke? YES / NO

Are you currently taking any medication? YES / NO

If yes, please specify:

Have you had surgery within the past 12 months? YES / NO

If you have circled YES for any of the above, you need a signed medical clearance from your doctor, or alternatively a signed self-clearance, before starting an exercise program.

Doctors clearance:

Date: / /

OR

Client's self-clearance of the above conditions (if over 18 years of age)

I, _____ guarantee that I am physically and mentally well enough to take part in any exercise program prescribed for me.

Signature of Participant (*if 18 years of age or older*)

Date

OR

Parent or Guardian's clearance of the above conditions (if under 18 years of age)

I, _____ guarantee that _____
(the minor participant under my care) is physically and mentally well enough to take part in any exercise program prescribed for them.

Signature of Parent or Guardian (*if under 18 years of age*)

Date

Exercise History

Are you currently playing any sports? YES / NO

If yes please specify:

Do you have any martial arts experience? YES / NO

If yes, please specify:

Have you been to a gym before? YES / NO

Have you done weight training before? YES / NO

Have you done kick-boxing before? YES / NO

Have you done boxing before? YES / NO

Do you have any exercise likes?

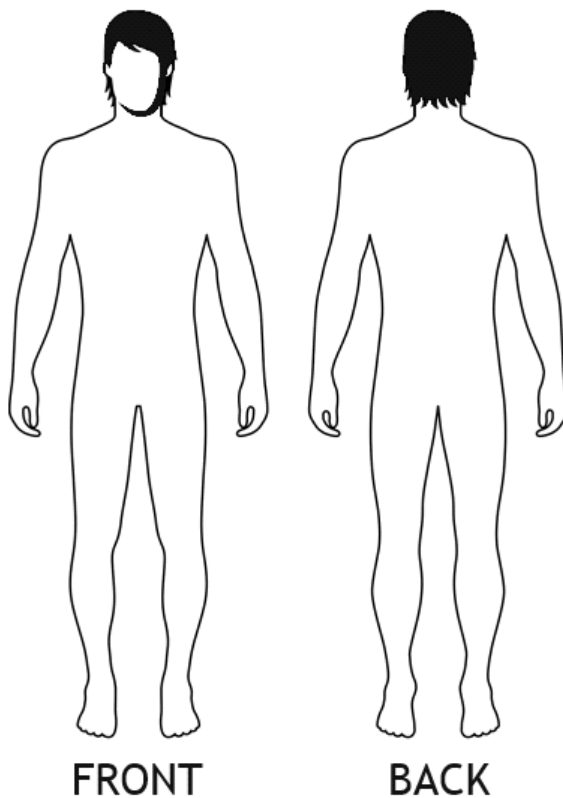
Or dislikes?

Physical Condition

Do you have any injuries? YES / NO

Have you had any injuries recently? YES / NO

Please circle on the body below any problem areas if applicable:



Which days of the week can you commit to working out?

Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐

How much time do you have to work out on those days?

30 minutes ☐ 60 minutes ☐ 90 minutes ☐ Other (please specify) _____

What are your exercise goals?

What are your goals for the next 3 months?

All information given here is true and correct and if there are any changes to my health, contact details, doctor's details, or emergency contact, I will advise Muay Thai Movement as soon as possible.

I am aware that there are risks involved with exercise and I agree that by signing this form I am accepting responsibility for the risks associated with the sport I am participating in. I agree to follow all instructions given to me as failure to do so can lead to injury of myself or another participant.

I have been advised that Muay Thai Movement will from time to time take photos and/or videos of classes for promotional reasons and I give permission for these to be used.

I, or the parent/legal guardian of the minor participant named below, understand and agree to abide by all policies, rules, and regulations of Muay Thai Movement. I understand that, in its sole discretion, Muay Thai Movement or its representative may revoke membership without compensation at any time should my or the minor participant's actions or general behaviour impede the operation of Muay Thai Movement or the rights or welfare of any person. Reasons for termination may include, but are not limited to: inappropriate conduct or other behaviour by myself or the minor participant named below, such as persistent use of threatening language or inappropriate comments; physical violence; emergencies; or health or safety considerations.

Signature of Participant (*if 18 years of age or above*)

Date

Print name

OR

Signature of Parent or Guardian (*if under 18 years of age*)

Date

Print name