

# ROCK SOLID FITNESS

## Registration Form

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_

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

Referred By: \_\_\_\_\_ Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

PAR-Q / Risk Factors - (If you answer yes to any —please talk with your doctor about becoming physically active)

1. Has your doctor ever said you have a heart condition and should only do activity recommended by a doctor? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_
2. Do you feel pain in your chest when you perform physical activity? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_
3. In the past month, have you had chest pain when you were not doing physical activity? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_
4. Do you lose your balance because of dizziness or do you ever lose consciousness? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_
5. Do you suffer from shortness of breath at mild exertion or have difficulty breathing? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_
6. Do you have bone or joint problem that could be made worse by a change in physical activity? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_
7. Is your doctor currently prescribing drugs for your blood pressure or heart condition? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_
8. Do you know of any other reason why you should not do physical activity? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_
9. Are you above 40 years of age and not currently physically active? **YES** \_\_\_\_\_ **NO** \_\_\_\_\_

Please list any injuries or health conditions that you are aware of?

What is your biggest obstacle/s when it comes to getting in shape?

What are the main goals that you would like to achieve during this workout challenge? (Be Specific)