Inspired LIFESTYLES WITH DONNA

(All Information received is to understand your unique challenges and goals. All information is confidential and will not be shared). Lifestyles, Ltd. recommends and requests that you consult your Physician before beginning this water exercise program.

Name: **D.O.B**

Physical Address:

Tel (h) **(cell)** **E-mail:**

In case of emergency notify: **Telephone:** **Email:**

Current Level of Health/Fitness:

Are you accustomed to physical exercise? **Do you smoke?**

Are you currently under a Doctor's care? **If so, please share anything significant**:

General Medical Information: **(if yes, please indicate so with an X or circle)**

High blood pressure **Heart disease** **Chest pain** **Injury** **Epilepsy**

Shortness of breath **Diabetes** **Asthma/Emphysema** **Back Pain**

Depression **Anxiety** **Neurological Disorders** **Cancer** **Pregnant**

Dizziness **Nausea/Gastrointestinal** **Orthopedic problems** **Overweight**

Details

Are you on any medications that may affect your ability to safely participate? Please explain:

This is how I would like to benefit from participation in water fitness:

I acknowledge that the information on this form is true and correct to the best of my knowledge.

Name: **Date:** **Signature**

(please print)

Upon registration with the accompanying waiver, you will receive Training Guidelines.