



REGISTRATION FORM

Full Name:							
Sex		Weight :	Height :	Date Of Birth			
				m	d	y	
Street Address :							
City:				State:		Zip:	
Home Phone:				Cell Phone:			
Email:							
Emergency Contact :				Phone:			

Goals

<p>Check the top 3 areas you would like to see improvement:</p> <p> <input type="checkbox"/> Fitness <input type="checkbox"/> Fat loss <input type="checkbox"/> Toning <input type="checkbox"/> Conditioning <input type="checkbox"/> Flexibility <input type="checkbox"/> Strength <input type="checkbox"/> Balance <input type="checkbox"/> Confidence </p>	<p>What are you specific or personal goals?</p>
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How did you hear about us?

Flier / Mail : Website / Internet Newspaper

Friend / Referral : Name Phone :

Have you attended any EXERCISE class before?
 If Yes Why _____
 Ailments (If any) _____

Signature