

# Mind Body WORKS

Village Commons • 620 Village Drive • Virginia Beach, VA, 23454  
757.351.3332 • fax: 757.351.2544

## Registration Information (Please Print)

Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

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

Client: \_\_\_\_\_  
(Last Name) (First Name) (Initial)

Responsible Party (if a minor): \_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Sex: Male\_\_ Female\_\_ Age: \_\_\_ **Birthdate:** \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employed: \_\_ Unemployed: \_\_ Student: \_\_ School Attending: \_\_\_\_\_

Patient Employed By: \_\_\_\_\_

Business Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Business Name and Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_ Relationship: \_\_\_\_\_

**Social Security #:** \_\_\_\_\_ Spouse's Social Security #: \_\_\_\_\_

List **all** current medication and state the condition they are used for: \_\_\_\_\_

\_\_\_\_\_

List **all** previous surgeries and give dates: \_\_\_\_\_

\_\_\_\_\_

\_\_\_ I have consulted with a physician before starting Personal Training

Or

\_\_\_ I have decided to independently not to consult with a physician because I have no reason to suspect any problems.

**I understand and agree that I participate at my own risk.**

\_\_\_\_\_  
**Client/Responsible Party Signature**

\_\_\_\_\_  
**Date**