Membership Application

Fitness Central

406-535-BFit (2348)
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Lewistown, MT 59457
fitnesscenterallewistown@gmail.com
www.fitnesscentrallewistown.com

Today's Date: _____/_____/_____

First Name _____ Last Name _____

Mailing Address_____

City _____ State _____ Zip _____

Home Phone (_____)_____-_____ Cell Phone (_____)_____-_____

Email Address _____

❑ Male ❑ Female Birth Date _____/_____/_____

Emergency Contact Name _____

Emergency Contact Phone (_____)_____-_____

Membership Type ❑ Individual ❑ Senior ❑ Student ❑ Couple ❑ Family

Membership length ❑ Daily ❑ Weekly ❑ Monthly ❑ 6-month ❑ Yearly

Payment Information

Payment Type ❑ Cash ❑ Check Check #_____ Payment Amount $_____

❑ Paid In Full ❑ Auto-Withdrawal ❑ Voided Check Attached

FOR OFFICE USE ONLY

Effective Date of Membership _____/_____/_____ ❑ NEW

Membership End Date _____/_____/_____ ❑ RENEWAL

Name _____ Today's Date: _____/_____/_____

This is confidential information for health professional use only.

How would you describe your current physical condition?

❑ Unwell ❑ Overweight ❑ Unfit ❑ Healthy ❑ Fit

What regular exercise do you currently do? _____

Have you ever had OR do you have?

- Stroke ❑ No ❑ Yes
- Diabetes ❑ No ❑ Yes
- Epilepsy ❑ No ❑ Yes
- Dizziness ❑ No ❑ Yes
- High blood pressure > 140/90 ❑ No ❑ Yes
- Are you pregnant? ❑ No ❑ Yes If Yes, due date _____/_____/_____
- Given birth in the last 6 weeks? ❑ No ❑ Yes
- Have you been hospitalized recently? ❑ No ❑ Yes If Yes, when? _____
- Heart Condition ❑ No ❑ Yes
- Heart murmur ❑ No ❑ Yes
- Palpitations or pain in the chest ❑ No ❑ Yes
- Fainting ❑ No ❑ Yes
- Low blood pressure ❑ No ❑ Yes
- Are you dieting or fasting currently? ❑ No ❑ Yes
- Are you taking any medications or supplements that advise you to be cautious while exercising? ❑ No ❑ Yes
- Are you currently taking any hormone supplements? ❑ No ❑ Yes

Please Note - If you have circled YES to any of the above OR you are NOT SURE – We recommend that you see a Doctor PRIOR to beginning an exercise program. ***Initial***_____

Have you ever had OR do you have?

- Arthritis ❑ No ❑ Yes
- Cramps ❑ No ❑ Yes
- Vision or hearing loss ❑ No ❑ Yes
- Did you OR do you smoke? ❑ No ❑ Yes
- Muscular pain ❑ No ❑ Yes
- Asthma or other respiratory illness ❑ No ❑ Yes
- Allergies ❑ No ❑ Yes

Do you experience any pain OR have you had major injuries in the following areas?

- Neck ❑ No ❑ Yes
- Knees ❑ No ❑ Yes
- Ankles ❑ No ❑ Yes
- Shoulders ❑ No ❑ Yes
- Back ❑ No ❑ Yes

Have you had any major surgery? ❑ No ❑ Yes What/When_____

Please read the following advice carefully.

- Work at a low level on your first few visits & concentrate on learning correct techniques.
- Be sure to limit yourself to a pace where you can still talk comfortably.
- We recommend that you exercise at least three times a week to improve your general fitness.
- If you suffer any injury, illness or condition in the future, please tell us. ***Initial***_____

What are your fitness goals? *(check all that apply)*

❑ Weight loss ❑ Muscular Endurance ❑ Muscular Strength ❑ Relaxation ❑ Flexibility

❑ Injury Rehabilitation ❑ Toning ❑ Increase Energy Level ❑ Stay Fit ❑ Social

Would you be interested in any of these services?

- Personal Training ❑ No ❑ Yes ❑ Maybe
- Nutrition Counseling ❑ No ❑ Yes ❑ Maybe

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