REGISTRATION FORM

Jersey Shore Wellness Studio
108 Main Street Suite 7 - Oceanport, NJ
www.jerseyshorewellness.com

Name:

Date of Birth:

Address:

Cell Phone #:

Email:

Emergency Contact & Phone #:

Booking Policy: Our classes are small in structure to create a personalized, comfortable and safe training environment for you. Please RSVP within AT LEAST 24 hours ensure your spot in class!
If we do not have any RSVP's 2 hours prior to a class the class will be cancelled for that day.
Please RSVP to am classes by 9pm the night prior to the class.

Cancellation Policy: All personal training session require 24 hour cancellation as a courtesy to your trainer.
All group classes require 2 hours advance cancellation to allow wait listed peers to be notified and potentially enroll in that class.
All classes and training sessions cancelled outside of these windows, including no show appointments, will be charged in full.

**Our class schedule changes in an effort to accommodate the evolving needs of our clients. For the most up to date information please check our website and email notifications.*

You are our best advertisement! If you love us - tell your friends about us!
****Refer a friend who registers for a package and receive a 10% your next regular price pack!***

**All packages will expire 2 months from their date of purchase.*
**Packages are non-transferrable and non-refundable.*

Physical Activity Readiness Questionnaire:

1. Has a doctor diagnosed you with a heart condition and restricted you to only perform physical activity recommended by a doctor?
YES / NO
If YES, Explain:

2. Do you feel pain in your chest when you do physical activity?
YES / NO
If YES, Explain:

3. In the past month, have you had chest pain when you were not doing physical activity?
YES / NO
If YES, Explain:

4. Do you lose your balance because of dizziness or do you ever lose consciousness?
YES / NO
If YES, Explain:

5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
YES / NO
If YES, Explain:

6. Are you currently taking prescription medication (example blood pressure or heart condition)? YES / NO
If YES, Explain:

7. Do you know of <u>any other reason</u> why you should not do physical activity?
YES / NO
If YES, Explain:

Additional Questions:

1. Have you ever had any pain or injuries (ankle, knee, hip, back, shoulder etc).
If YES, Explain:

2. Have you ever had any surgeries?
If YES, Explain:

3. Has a medical doctor ever diagnosed you with a chronic medical condition such as hypertension (high blood pressure), coronary heart disease, coronary artery disease, high cholesterol or diabetes?
If YES, Explain:

X_____
(NAME/DATE/SIGNATURE)