



Program Registration Form

Complete all information below, and return to tryfitness@hawaii.rr.com or by fax to (808) 946-0346

Personal Information:

Name:			Date:		
Address:			Sex:		
City:	State:	Zip:	Age:	Date of Birth:	
Email Address:			Height:	Weight:	
Home Phone:		Work Phone:		Cell Phone:	
Emergency Contact Name:			Emergency Contact Phone #:		
Physician Name:			Physician Address:		

Program Information:

Check Here:	Program:	Session Dates (circle one where applicable):	Cost: + tax
	12 Week Fun & Fitness	Spring Summer Fall Winter	\$375/\$392.62
	Boot Camp for Women	Month:	\$150/\$157.05
	Boot Camp 90 Day Special	May 24 – August 27	\$400/\$418.80
	Cycling Training for Women	Summer Winter	\$300/\$314
	Marathon Training for Women		\$425/\$445
	Fall Conditioning Program	Month:	\$80/\$83.76
	Team Try Fitness: Ironman 70.3 Hawaii		\$450/\$471.15
	Team Try Fitness: Tinman Triathlon		\$425/\$445
	Team Try Fitness: Na Wahine Triathlon		\$300/\$314
	North Shore Summer Swim Series Prep	May 29 – June 19	\$60/\$62.82
	Rough Water/Open Ocean Clinic	July 17 – August 28	\$80/\$83.76

Payment and/or deposit due on the first day of program. Cash or check accepted.

Health & Lifestyle:

- Have you ever been diagnosed as having any of the following? (Circle appropriate answer)

Arthritis	YES NO	Diabetes	YES NO	High Blood Pressure	YES NO
Asthma	YES NO	Heart Disease	YES NO	High Cholesterol	YES NO
- Have you ever had a major illness and/or surgeries? YES NO
If yes, please explain:
- Do you have any current medical problems or incompletely healed injuries? YES NO
If yes, please explain:
- Are you presently taking any medications? YES NO
If yes, please list names, reasons for taking them and dosage of each:
- Do you smoke? YES NO
If yes, how much do you smoke and for how long?
- Do you have a family history of heart disease (heart attack or stroke)? YES NO
If yes, who and what age at onset? (Only immediate family)
- Rate your general level of physical fitness: EXCELLENT GOOD FAIR POOR
- What type of work do you do? (Occupation, include physical demands)
- Rate your level of stress: (Low) 1 2 3 4 5 6 7 8 9 10 (High)
- Do you exercise? YES NO If yes, for how long?
Describe your routine (for example, type of routine, duration, frequency, intensity):
- What goals do you hope to achieve through this program? (Be as specific as possible)
- After reviewing this questionnaire, it may be necessary for me to obtain a medical clearance from your physician before beginning an exercise program with you. YES NO

Signature: _____

Date: _____