

90 DAY CHALLENGE

Registration Form

Date: _____

Name: _____ Birth Date: _____

Phone: _____ Cell: _____

Address: _____

City, State, Zip: _____

Physician Name: _____

Medical Conditions: _____

Describe your current exercise program: _____

What are your overall health goals? _____

How did you hear about this event? _____

What do you think you weigh: _____ How much weight would you like to lose? _____

Are you or have you ever been overweight? _____ Do you lack energy? _____

What motivated you to come today? _____

Is your family supportive? _____

It takes about 30 minutes, 3 times a week to get in shape. Will you demand this small amount of time from your busy schedule? _____

OFFICE USE ONLY

Gender: M F

BMI _____

Ideal Body Wt.: _____

Age: _____

Fat % _____

Caloric intake to lose _____

Height: _____

BMR _____

PAID _____

Weight: _____