SYNERGY
PHYSICAL THERAPY
EXPERIENCE • PERSONAL CARE • RESULTS

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Fitness Intake Form

Last Name_____ First Name_____ Middle Initial_____

Home Address_____

City_____ State_____ Zip code_____

Home Phone Number ( ) _____

Work/ Cell Number ( ) _____

Age_____ Date of Birth _____/_____/_____

Email address_____

How did you hear about us? Posted Sign Friend Past Patient Other_____

Emergency Contact
Name_____ Phone Number ( ) _____
Relationship to You_____ Alternate Number ( ) _____

Payment Information:
Payment is due the first of each month.

I understand that in order to receive uninterrupted benefits of membership payment is due at the first business day of every month that I wish to participate in Synergy's Fitness Program.
I hereby agree that I have not undergone any medical procedures/ surgeries in the past 3 months that would require medical clearance prior to initiating exercise program.

Signature: _____ Date: _____

Please fill out the information below as it is helpful to us to e aware of any pre-existing conditions prior to initiating your fitness program. We do recommend that you consult your primary care physician prior to starting a fitness program.

Current Medications:_____

_____

Allergies:_____

Please check any of the conditions that you have ever had or have now:

☐ Anemia	Depression	Hepatitis	Pacemaker
☐ Arthritis	Diabetes	High Blood Pressure	Respiratory Probs
☐ Asthma	Dizziness/ Fainting	Kidney Problems	Seizures
☐ Cancer	Fractures	Low Blood Pressure	Substance Abuse
☐ Cardiac Condition	Headaches	Metal Implants	Thyroid Problems

☐ Any other Medical Conditions:_____

Are you currently pregnant? Y N N/A If yes, _____weeks/months