

Wolfpack Boxing Club Tracking Sheet



Date ____/____/____

Name _____

Address _____

Email Address _____

Occupation _____

Days per week ____ Hours per week ____

Travel? YES NO

If Yes, hours per week out-of-town ____

How did you hear about Wolfpack Boxing? _____

If referred by current member, please list: _____

Have you ever had any training before? YES NO

Where? _____

How Long? _____

Instructor? _____

DOB/Age _____/____

Home Phone () _____ - _____

Work Phone () _____ - _____

Marital Status _____ # of Children _____

Emergency Contact:

Name _____

Phone: _____

What is your reason for training?

- | | |
|--|---|
| <input type="checkbox"/> Physical Fitness | <input type="checkbox"/> Self-Confidence |
| <input type="checkbox"/> Stress Management | <input type="checkbox"/> General Interest |
| <input type="checkbox"/> Self-Defense | <input type="checkbox"/> Relaxation |
| <input type="checkbox"/> Self-Discipline | <input type="checkbox"/> Other _____ |

Health and Medical Record

Are you exercising regularly? YES NO

If Yes, what type? How often? -

Do you consider your eating habits healthy? _____

If No, why?

Do you smoke? YES NO

Drink? YES NO OCCAS.

Are you currently taking any medications? YES NO

If Yes, what type(s)?

Have you ever had surgery? YES NO

If Yes, what type?

When?

Do you have any of the following problems?

- | | |
|--|---|
| <input type="checkbox"/> Heart condition | <input type="checkbox"/> Lack of energy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Back problems |
| <input type="checkbox"/> Lack of strength | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Blood Pressure (High) | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Blood Pressure (Low) |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Bronchitis |

Signature of applicant:

Printed name:
