Health Quest

Physical Therapy & Fitness Center, Inc.
Fitness Center Membership Form

☁Single ☁Double ☁Family

Name (Last) _____ (First)_____ (Middle Initial)_____

Address (Street, Apt.#, P.O. Box)_____

City_____ State_____ Zip Code_____

Birth Date_____ Home Phone_____ Cell#_____

Emergency Contact_____ Phone #_____

Health Concerns _____

_____

Important! All health concerns must be discussed with your physician before beginning any exercise program.
*****I certify that I have spoken to my doctor concerning my health concerns and have been cleared to participate in this fitness program at Health Quest.**

Signature:_____ Date: _____

(To be completed if member is under18 years of age)

Parent/Guardian's Name: _____

Parent/Guardian's Signature:_____ Date:_____

Relationship to Minor:_____

Address (Street, Apt.#, PO Box):_____

City_____ State_____ Zip Code_____

Home Phone_____ Work #_____

Employer_____

Additional Members on this Membership Account (Please list):

_____ _____

First Name Last Name DOB First Name Last Name DOB

_____ _____

First Name Last Name DOB First Name Last Name DOB

In order for us to serve you better, please answer the following:

How did you hear about us? ☁Postcard mailer ☁Newspaper ☁Phone Book ☁Word of Mouth ☁Radio
Other_____

Primary Interests: ☁Cardio ☁Tone & Strengthen ☁Weight loss ☁Aerobics
Other_____