Date: ______________________

The Cantrell Wellness Center

Member Information

Name: ____Age:_______ Date of Birth: ____/____ /____
(First, MI, Last)

Address: ____
Street & Number City State Zip

Telephone: (____) ________________ Cell/mobile phone#: (_____) __________________ Sex: _____

Email Address: ____

Marital Status

M S D W

☐ ☐ ☐ ☐

Employment Status

☐ **Employed** ☐ **Unemployed** ☐ **Student** ☐ **Retired**

Your Employer: _____________________________________ Work Phone#: _______________________

Spouse/Guardian Information

Spouse /Guardian Name: _______________________________________ Date of Birth: ____/____ /____
First MI Last

Spouse's Employer Name: ___________________________ Spouse Phone#: (____) ________________

Emergency Contact: _______________________________ **Phone Number:** (___) ___________________

How Did You Hear About Our Office?

___ Former Patient Cantrell Center: Who? ___________________________
___ Yellow Pages: Which Publication? __________________
___ You were a former patient Cantrell Center. Date last seen. __________
___ Employer: Who? ____________________________
___ Friend/Family
___ Other: ____

Friends of The Cantrell Center and The Cantrell Wellness Center are very special to us. Did anyone "*other than*" your physician recommend you to The Cantrell Wellness Center? We would like to thank them.

Name: ______________________________________

Address: _____________________________________

____

Personal Medical History

PLEASE CHECK ALL THAT APPLY:
☐**SMOKE** ☐**DRINK** ☐**DRUGS** ☐**EXPOSED TO HIV** ☐**PREGNANT – IF SO, HOW LONG?** ____________

	AIDS		HIGH BLOOD PRESSURE		PACEMAKER
	ALLERGIES		HIGH CHOLESTEROL		PARKINSON'S DISEASE
	CANCER		IMMUNE DEFICIENCY		PERIPHERAL NEUROPATHY
	CEREBRAL PALSY		IMPAIRED VISION		RHEUMATOID ARTHRITIS
	DIABETES		INCONTINENCE		SHORTNESS OF BREATH
	EPILEPSY		INFECTIOUS HEPATITIS		STROKE
	EXCESSIVE BLEEDER		JOINT REPLACEMENT		SWELLING
	FIBROMYALGIA		LUPUS		TUMOR
	FRACTURES		MIGRAINES		
	GOUT		MULTIPLE SCLEROSIS		OTHER:
	HEART CONDITION		OSTEOPOROSIS		

Are you under the care of a cardiologist? If so, who? ____

Please list your medications and indicate the reason you have been prescribed each:

Medication: __________________________ prescribed for: _______________________
Medication: __________________________ prescribed for: _______________________
Medication: __________________________ prescribed for: _______________________
Medication: __________________________ prescribed for: _______________________
Medication: __________________________ prescribed for: _______________________
Medication: __________________________ prescribed for: _______________________
Medication: __________________________ prescribed for: _______________________
Medication: __________________________ prescribed for: _______________________

Are you currently experiencing any pain? If so, then describe symptoms and location:
____
____

Physician seen for wellness physical: _________________________ Date of visit: _____________________
May we send progress reports to him/her? ☐ Yes ☐ No

Who is your family physician? (Primary Care Physician) ____
May we send progress reports to him/her? ☐ Yes ☐ No

Would you be interested in Personal Training? _____ Yes _____ No

Would you be interested in attending a Fitness Boot Camp? _____ Yes _____ No

Would you be interested in attending educational seminars? _____ Yes _____ No

What personal fitness goal would you like to achieve here at the Cantrell Wellness Center?
____
____

What area of your body would you like to improve on the most? ____________________

How many times a week do you see yourself using the facility? _____________________