Intake Form

First name:	**Middle name:**	**Last name:**
Street address:		
City, state, and zip code:		
Home phone number:	**Cell phone number:**	
Email address:		
Date of birth:	**Gender:** ◯ Male ◯ Female	
Height:	**Weight:**	
Ethnicity / race:	**Smoke:** ◯ Yes ◯ No	
Language spoken at home:		
List any prior medical conditions:		
List any current medical conditions:		
List all prior surgeries:		
List the names and phone numbers of two emergency contacts:		
Given your schedule, what times and dates are you generally available to participate in the program?		
Do you have any special medical conditions that might require emergency responses on our part such as seizure disorder, hypoglycemia, food or bee sting allergies, etc.? If so, please describe.		