

# Green Means Registration Form

Please complete and return via  
email: [sales@mygreenmeans.com](mailto:sales@mygreenmeans.com) or fax: 413.677.3732

## Member Data (Please Print)

Name _____	_____	_____	Today's Date _____
First	Last	M.I.	
Date Of Birth _____	Gender: M	F	
I am over 18 years of age:    yes    no			
If no, Parent or Legal Guardian Signature required. Name: _____ Signature: _____			
How did you hear about us? _____ Referred by: _____			

## Current Contact Information

Street _____	
Apt.# _____	Email Address _____
City/State/Zip _____	
Home Phone # (____)- _____ - _____	Work Phone # (____)- _____ - _____

## Emergency Information

Emergency Contact Person	
Name _____	Phone # (____)- _____ - _____
Physician's Name _____	Phone # (____)- _____ - _____

## Medical History (If you are a returning member, please note the sections that have changed)

1. Are you allergic to any medication (aspirin, penicillin, sulfa, etc.)? List Medications: _____	<b>yes</b>	<b>no</b>
2. Do you take any prescribed medication on a permanent or semi-permanent basis? List Medications: : _____	<b>yes</b>	<b>no</b>
3. Do you have a seizure disorder (epilepsy)? List Medications: : _____	<b>yes</b>	<b>no</b>
4. Do you have diabetes Adult or Juvenile?	<b>yes</b>	<b>no</b>
5. Have you ever been found to be anemic (low blood count)?	<b>yes</b>	<b>no</b>
6. Do you have High Blood Pressure (hypertension)? List Medications: : _____	<b>yes</b>	<b>no</b>
7. Heart Disease:	<b>yes</b>	<b>no</b>
8. Lung Disease:	<b>yes</b>	<b>no</b>
9. Kidney Disease:	<b>yes</b>	<b>no</b>
10. Liver Disease:	<b>yes</b>	<b>no</b>
11. Do you have asthma? List Medications: : _____	<b>yes</b>	<b>no</b>
12. Have you ever had a severe neck injury? Describe: : _____	<b>yes</b>	<b>no</b>
13. Have you ever been knocked out? Describe: _____	<b>yes</b>	<b>no</b>
14. Do you wear glasses or contact lenses?	<b>yes</b>	<b>no</b>
15. Have you had a broken bone or fracture in the past 2 years?	<b>yes</b>	<b>no</b>
16. Have you ever injured your back? Describe: : _____	<b>yes</b>	<b>no</b>

17. Have you had knee pain in the past 2 years that has disabled you for longer than a week? Describe: : _____	<b>yes</b>	<b>no</b>
18. Do you have other physical conditions which cause pain? Describe: : _____	<b>yes</b>	<b>no</b>
19. Detail any surgical procedures: _____		
20. What are your goals for the next three months? _____		
21. Have you had your body fat tested?	<b>yes</b>	<b>no</b>
22. Are you training for a specific event? _____	<b>yes</b>	<b>no</b>

**Program Information**

Program/ Class Choice: _____	Location (if applicable): _____
T-Shirt Size: Adult-    M    L    XL    Child-    S    M    L	

*I have read and understand the 1) Informed Consent Agreement 2) Participant Activity Readiness Questionnaire, 3) Waiver of Liability, Indemnity Agreement and Assumption of Risk, and 4) Green Means Policies and agree to be bound by them, as indicated by my signature below.*

Signature \_\_\_\_\_

Legal Guardian Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Print Name \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_

**Office Use Only**

Program/ Class _____
Expiration Date _____ Month /Day/ Year
Payment Type (check one)    ___ Cash    ___ Check    ___ Paypal
Check # _____ Amount _____ Staff Initials _____