



Body Specs, Inc.

734.827.2744

Date: _____

Services:

Monthly Training Packages \$_____ per month

Purchase Sessions # Sessions _____ \$_____

Injury Management / Assessment \$_____

Payment: Check Cash Credit Card EFT*
*(please sign EFT authorization form)

CC# _____ Exp Date _____

Signature: _____

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Emergency Contact Person: _____

Emergency Phone: _____ Relationship: _____

MEDICAL HISTORY

List any medical problems or physical conditions that you are having or have had in the past:

MEDICATIONS:

LIST ALL SURGERIES:

Type of surgery: _____ Date: _____

Type of surgery: _____ Date: _____

Type of surgery: _____ Date: _____

Type of surgery: _____ Date: _____

Type of surgery: _____ Date: _____

Type of surgery: _____ Date: _____

Name of Family Physician: _____

Phone Number: _____