Wellness Hours: **5am – 8pm M-F**
7am – 10am Sat
Closed Sunday

Turning Point Therapies, Inc.
Adult Wellness Center
Membership Form

Please print legibly& present driver's license to verify you are 16 years of age or older.

First: _____Middle:_____Last:_____
Name I go by: _____ Birth date: _____
Street: _____ City: _____
State: _____ Zip code: _____ Email address: _____
Home phone number: _____ Cell: _____
Gender: _____Male _____Female

Membership Type:

_____ Student/ Active Duty Military Discount $20.00 (must show student I.D./military I.D.)
_____Adult Wellness Monthly Fee $30.00
_____Additional Family Member Monthly Fee $20.00
Please list family member(s) name(s):

_____Yearly Wellness Membership $330.00 (includes the 12th month free)

Medical Information:
Please list any medications or allergies we should alert First Responders to in the event of a medical emergency:

Name of Primary Physician:_____ Hospital:_____

Please check any known medical conditions:

___Heart Disease
___High Cholesterol
___Multiple Sclerosis
___Thyroid Disease
___Severe Obesity
___High Blood Pressure
___Pulmonary Disease
___History of Heart Attack
___Low Blood Pressure
___Fibromyalgia
___Joint Replacement
___Kidney Disease
___History of Stroke
___Alzheimer's Disease
___Chest Pain
___Epilepsy
___Arthritis
___Asthma
___Diabetes
___Back Injury

Continued on back

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(Page 2 of the Wellness Program Information Form)

Emergency Contact Information: Please list a primary or local emergency contact:

Name: _____ List relationship: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____

Please list a family member or additional emergency contact:

Name: _____ List relationship: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____

Do you smoke? ___Yes ___No
If yes, how many packs per day? _____

Height: _____ Weight _____ Blood Pressure _____

I hereby apply for membership with Turning Point Therapies, Inc. Adult Wellness Program. I acknowledge that the program is a fitness and therapy clinic and its programs, and equipment are on a volunteer basis. The membership fee does not include any insurance coverage. I understand and acknowledge that certain inherent risks exist with all types of physical exercise regardless of whether I am supervised by an instructor or participate in such activity by my own discretion. If I am concerned with these risks or with my current health condition, I agree to consult my physician before beginning a new activity or exercise. I further agree that membership is on a monthly or yearly basis. I hereby agree to follow all of the polices of the clinic, and I agree that my membership is a privilege and may be revoked by the clinic's staff. Discretion

Signature of Member: _____ Date: _____