



TODAY'S DATE: _____ (MM/DD/YY)

WELCOME TO Sportsmetrics at THE STONE CLINIC. For the next six (6) weeks, you will dedicate yourself to a program that will strengthen your muscles, improve your agility and retrain your body in order to prevent injuries. Please fill out the information requested below and review the wavier and return to the Stone Clinic team. Thank you!

Patient's Name: _____
Last First MI

Address: _____
Street
City State Zip Code

Home Phone: (____) _____ Work: (____) _____ Cellular: (____) _____
(Please circle best number to reach you during the day)

E-Mail Address: _____ Sex: ☐ M ☐ F

Date of Birth: ____/____/____ Age: _____
M D Y

Emergency Information: Person to Call: _____

Relationship: _____ Phone: (____) _____

How did you learn about The Stone Clinic? Doctor / Former Patient / Friend / Internet / Yellow Pages / Other?

Name of Referral: _____

Training History/Sports Played: _____

Injuries/Areas of Concern: _____

Class Goal(s): _____

PLEASE CHECK PAYMENT METHOD:

☐ Cash ☐ Check ☐ Mastercard / Visa ☐ American Express

Credit Card Number: _____ Exp. Date: _____

Security Code: _____ (Shown on reverse side of card in the signature label)

Credit Card Authorization Signature: _____

