

# NEUROBALANCE

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## C E N T E R

1529 S. Grove Avenue, Barrington, IL 60010 | Phone 847.800.6162 | Fax 847.660.6389

(Please Print)

Name \_\_\_\_\_

Date of Birth (mm/dd/yyyy) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ ZipCode \_\_\_\_\_

Home Phone \_\_\_\_\_ Email: \_\_\_\_\_

Cell Phone \_\_\_\_\_ Cell Phone Carrier \_\_\_\_\_

Emergency Contact Name and Relationship \_\_\_\_\_

Emergency Contact Phone Number \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Which services brought you here? \_\_\_\_\_

Please check all programs/services that interest you:

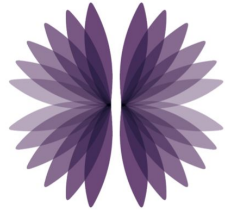
Group Fitness Classes (FitMS, FitPD, other)	Chiropractic	Disease Management Consultation
Rock Steady Boxing	Nutritional Counseling	Infusion Services
PowerPlate Training	Weight Management	Educational Programs
Acupuncture	Therapeutic Massage	Physical Therapy
Personal Training	Exercise Research Study	Hand, Occupational Therapy
Transportation Assistance	Financial Assistance	Tour                      Volunteer

If you have any health conditions that might affect your safety or ability to exercise, please explain. \_\_\_\_\_

\_\_\_\_\_

Has your healthcare provider released you to exercise? \_\_\_ yes \_\_\_ no

Signature \_\_\_\_\_ Date \_\_\_\_\_



## Liability and Media Waivers

Liability Waiver for all persons providing or receiving services within or as a result of association with fitMS NeuroBalance Center NFP

I hold fitMS NeuroBalance Center, NFP harmless of claims, demands or causes of action (including the cost of defense thereof) as a result of any personal injury or personal property loss or damage suffered by myself arising out of or connected with the use of fitMS NeuroBalance Center facility located at 1529 S. Grove Avenue, Barrington IL 60010, including equipment and/or services regardless if such injury, loss or damage was foreseeable or the result of active or passive negligence of the office space, building, workout rooms, its Partners or Employees.

I agree

I do NOT agree

## Media Release

I allow fitMS NeuroBalance Center, NFP to publish or broadcast my image, likeness or name for promotional purposes associated with fitMS NeuroBalance Center.

I agree

I do NOT agree

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

Staff to Complete Witnessed by:

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
Signature