

HMHB Intake Form



Step 1 Veteran Information *REQUIRED

Name: _____ **Birthday:** ____-____-____ **Age:** ____
Address: _____ **Ethnicity:** _____
City: _____ **Zip:** _____ **State:** ____
Email: _____
Gender: Male Female **T-Shirt Size:** ____ **Phone 1:** ____-____-____ **Phone 2:** ____-____-____
Branch Served: _____
Years Served: ____

Does veteran use a service animal? ☐ Yes ☐ No

Does veteran have a seizure disorder? ☐ Yes ☐ No Date of last seizure: ____-____-____ *If yes, complete Seizure Information Form

Step 2 Fitness Partner

Name: _____ **Birthday:** ____-____-____ **Age:** ____
Address: _____ **Ethnicity:** _____
City: _____ **Zip:** _____ **State:** ____ **Gender:** Male Female **T-Shirt Size:** ____
Email: _____ **Phone 1:** ____-____-____ **Phone 2:** ____-____-____

Step 3 Emergency Contact Information *REQUIRED

Emergency contacts should be someone other than Fitness Partner

#1 Name: _____ **Relationship:** _____
Email: _____ **Phone:** ____-____-____
#2 Name: _____ **Relationship:** _____
Email: _____ **Phone:** ____-____-____

Step 4 Medication

Attach additional information if needed.

Medication Name	Dosage	Time	Purpose/Reaction

Step 5 Allergies

Attach additional information if needed.

Does veteran have allergies? ☐ Yes ☐ No

Allergy	Reaction	Additional Comments

Step 6 Dietary Restrictions

Attach additional information if needed.

Does veteran have dietary restrictions? ☐ Yes ☐ No If yes, please list _____

Step 7 Approvals *REQUIRED

I grant photo permission for pictures to be taken and used in NEDSRA publications. ☐ Yes ☐ No

Signature: _____

Print Name: _____

Date: _____