



Courage Quest
Full Force Adrenal Response Training
Personal Empowerment & Self Defense Tactics

PRE-CLASS REGISTRATION & QUESTIONNAIRE

Personal Information (Part I)

Name: _____
 Address: _____
 City/ST: _____
 Zip Code: _____

Training Date: _____ 2010
 Age: _____
 Height: _____ Weight: _____

Your Contact No: _____
 Your Email: _____
 Occupation: _____

Gender: M _____ F _____

Spouse/Partner: _____

Marital Status:
 Single _____
 Married _____
 Separated _____
 Divorced _____
 Widowed _____

Do you have children? Yes _____ No _____
 (If yes, please fill in the chart below.)

Name	Age	Gender	Live w/ you?	Full-time?
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

How did you find out about us? _____

Please give your completed questionnaire and non-refundable registration fee of **\$59.00** (make check or money order payable to Safety First PPS) at least 2 weeks prior to the training date to the Safety First staff member that has given you this or mail to:

Safety First Personal Protection Strategies
 A WA Nonprofit Corporation
 8307 27th Street W
 University Place, WA 98466

The fee for this course has been purposefully kept low in an effort to make this important training affordable for everyone. For more information call 253-495-2985 or send an email inquiry to: ginny@safetyfirstpps.org

Personal Information (Part II)

1. Have you ever been the victim of a violent encounter? Yes No
If yes, what were the circumstances? _____

2. Have you ever experienced or witnessed any form of verbal abuse? Yes No
If yes, how did you react internally? _____
3. Has a friend or family member ever been the victim of a violent encounter? Yes No
If yes, please explain the circumstances. _____

4. Do you have frequent nightmares? Yes No
If yes, are they re-current? Yes No If yes, how often? _____
5. Do you have anxieties relating to your personal safety? Yes No
Do you have any phobias? Yes No
If yes, please list: _____
6. Are you working in a high stress environment? Yes No
If yes, does this produce feelings of frustration, resentment or anger? Yes No
7. Do you have feelings of inadequacy? Yes No
8. Do you suffer from chronic fatigue? Yes No from Depression? Yes No
9. Which of the following best describes your nature? Extroverted Introverted
10. What percentage of your day is fueled by fear in any form?
5% or less 10% 25% 50% 75% 100%
11. Choose the attributes you would most like to develop and list them in order of importance:
Assertiveness A. _____ (most)
Drive/Ambition B. _____
Confidence C. _____
Courage D. _____
Passion E. _____
12. Do you feel that your goals and dreams are attainable? Yes No
If no, what do you believe the obstacles are? _____

13. Where do you see yourself 5 years from now? _____

14. Have you ever placed yourself at risk or in harm's way to help another? Yes No
If no and given the opportunity, would you? Yes No
15. What do you hope to gain from this training? _____

Medical History (Part III)

1. Have you been under the care of a medical doctor during the past two years? Yes No
If yes, for what? _____
2. Have you taken any medication or drugs during the past two years? Yes No
3. Are you taking any medications, drugs or pills now? Yes No

4. Are you aware of having any allergic (or adverse) reaction to any medication or substance? Yes No
If yes, please list: _____
5. Have you been a patient in the hospital during the past five years? Yes No
If yes, please state reason: _____
6. Is there any body part that you feel may be of risk during this training session? Yes No
If yes, please give details: _____
7. Indicate which of the following you have had or have at present. Mark (✓) Yes or No for each item:

Heart (Surgery, Disease, Attack)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest Pains	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Artificial Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dislocations	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mitral Valve Prolapsed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hearing Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Prolapsed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis A/B	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	A.I.D.S.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	H.I.V. Positive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cortisone Medicine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bruise Easily	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swollen Ankles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neurological Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy or Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fainting or Dizzy Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervous/Anxious	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contact Lenses	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sight Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
8. Do you have or have you had any condition or problems not listed? Yes No
If yes, please list: _____
9. Women: Are you pregnant? Yes No If yes, _____ months.

CONFIDENTIALITY CLAUSE

I understand that the above information is required to protect my physical and emotional health and that it will be kept in strict confidence. Further, I certify that this is a correct and true depiction of my past and current history. In order to protect the integrity and effectiveness of this program for future participants as well as that of my class mates, I promise to keep the details regarding the individual exercises, and personal information revealed about other participants in the strictest confidence, and to reveal only the results of this training. I understand that failure to do so will in effect, rob others of the experience I have benefited from.

Student Signature _____ Date _____

ACTIVITY WAIVER

It is understood that all activities, exercises, workouts and drills undertaken by me are strictly voluntary and I can, at any time, elect not to partake in any activity, which I feel may involve some element of risk, damage, or injury to my person and/or property. It is further understood that my participation will be at my own risk and in consideration of such participation, I do hereby, for myself, my heirs, executors and administrators, release and discharge Safety First Personal Protection Strategies, the hosting organization and all other instructors and class participants or any member thereof, harmless from all liability for any injuries or damage to my person and/or property occasioned by or in any way connected with my participation in any said event.

Signed and agreed:

_____ Date _____
Student Signature

_____ Date _____
Parent Signature (Required only if student is under 18 years of age)



Personal Protection Strategies