ELITE INTEGRATED PILATES

Welcome to Our Studio!

Name: _____ Birthdate: _____

Mailing Address: _____ City_____State ___ ZIP _____

Phone: HOME (____) WORK (____) CELL (____)_____

Email address: _____ Occupation: _____

Hobbies: _____

How did you learn about our studio? (if someone referred you, please give the person's name)
Please describe any prior experience with the Pilates method:
What are your current fitness activities? How often?
What would you like to gain from Pilates training?
Where in your body do you store tension or have chronic pain?
Are you comfortable with physical touch?

INFORMED CONSENT AND WAIVER OF LIABILITY

I voluntarily agree to participate in a program of progressive physical exercise at Elite Integrated Pilates. I understand that there is always the possibility of serious personal injury associated with any physical exercise program and I hereby assume full responsibility for any and all such risks. In addition, I hereby release Elite Integrated Pilates and its agents and employees from any claim for personal injury, bodily injury, or consequential damages of any nature whatsoever. I accept complete responsibility for my health and well-being in any voluntary exercise/fitness program. I agree to advise my Pilates instructors of any changes in my health status. Any time I feel discomfort or pain, I agree to stop exercising immediately and to tell my Pilates instructor. I have accurately answered these questions and will not hold Elite Integrated Pilates responsible for any injury resulting from my failure to disclose all information requested.

Print Name _____ Signature _____ Date _____

PLEASE TURN OVER

HEALTH HISTORY QUESTIONNAIRE

The purpose of this **confidential** health history is to ensure your health and safety while exercising. Please mark and explain any of the following conditions you have/had, with **dates:**

MUSCULOSKELETAL

Bone, joint, or muscle disease ----------
Torn cartilage/ligament ----------
Tendonitis or bursitis ----------
Broken/fractured bone ----------
Back pain or problem ----------
Leg, knee, or hip pain ----------
Neck, arm, or shoulder pain ----------
Ankle, foot, wrist, or hand problem ----------
Arthritis ----------
Jaw pain/TMJ ----------
Muscle spasms/cramps ----------
Headaches or head injury ----------
Osteoporosis or osteopenia ----------
Other ----------

CIRCULATORY/RESPIRATORY

Heart condition ----------
Chest pain or severe shortness of breath ----------
Stroke or blood vessel disease ----------
High or low blood pressure ----------
Glaucoma ----------
Asthma/breathing difficulty ----------
Sinus problem ----------
Other ----------

SKIN

Allergies ----------
Rash, fungus, warts ----------
Any contagious skin disease ----------

MENTAL HEALTH

Anxiety/Depression
Sleep disorder----
Eating disorder---
Other ----------

NEUROLOGICAL

Numbness/tingling ----------
Chronic pain ----------
Fainting ----------
Seizures ----------
Dizziness/loss of balance ----------
Neurological disease ----------
Other ----------

OTHER

Cancer/tumors ----------
Diabetes ----------
AIDS/HIV ----------
Drug/alcohol use ----------
Smoking ----------
Overweight ----------
Communicable disease ----------
Digestive problems ----------
Urinary or pelvic floor problem ----------
Pregnant or post-parturn ----------
Serious illness or surgery ----------
Accident or injury ----------
Any current health problem or concern ----------

List any **allergies** ----------

List any **medications** you are taking ----------

Has your physician cleared you for exercise? ----------

Personal physician_____ Phone number_____

Emergency contact _____ Phone number _____