Client & Medical Information

Print Clearly

Name DOB

Address City Zip Code

Email Cell # Home #

Emergency Contact Relationship Contact #

What health goals do you hope to achieve through Purely Pilates?

How did you hear about us or who may we thank for referring you?

Current exercise program Physical Condition: Poor Fair Good Excellent

Please circle any that may apply, present or past injuries or illnesses:

Cervical Spine (Neck)	Lumber (lower back)	Thoracic (upper back)	Hips
Shoulders	Scoliosis	Asthma	Ankles
Headaches	Vertigo (dizziness)	Joint Replacements	Cancer
Arthritis	Diabetes	High/Low BP	Knees
Heart Problems	Hysterectomy	Hernia	
Osteoporosis	Disc Issues	Muscle Issues	

Other Issues we have not addressed _____

_____ initials **If during the course of activity should I become ill, sustain an injury or unconscious I authorize Purely Pilates Studio to contact emergency person, 9ll, & give necessary Medical information.**

Current Doctor: _____

Allergies to food or medicine: _____

Current list of prescription meds, over-the-counter and natural: _____

_____

Print Name **Sign** **Date**

This form is confidential and will not be released to the Media or General Public