



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, 911, & 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