



Your information will never be shared or used for any other purpose other than programming or to contact you regarding Studio business.

Name _____ Cell Phone _____

Work Phone _____ Home Phone _____

E-Mail Address _____

Address _____

City _____ State _____ Zip _____

Birth date ___/___/___ = Age ___ Ht. ___ Wt. ___ Occupation _____

Emergency Contact:

Name _____ Relationship _____ Phone # _____

	YES	NO
1. Has your doctor ever said you have a heart condition and that you should only perform physical activity recommended by a doctor?	<input type="radio"/>	<input type="radio"/>
2. Do you feel pain in your chest when you perform physical activity?	<input type="radio"/>	<input type="radio"/>
In the past month, have you had chest pain when you were not performing any physical activity?	<input type="radio"/>	<input type="radio"/>
3. Do you lose your balance because of dizziness or do you ever lose consciousness?	<input type="radio"/>	<input type="radio"/>
4. Do you have a bone or joint problem that could be made worse by a change in your physical activity?	<input type="radio"/>	<input type="radio"/>
5. Is your doctor currently prescribing you any medication for blood pressure or a heart condition?	<input type="radio"/>	<input type="radio"/>
6. Do you know of any other reason why you should not engage in physical activity?	<input type="radio"/>	<input type="radio"/>

If you have answered "Yes" to one or more of the above questions, consult your physician before engaging in physical activity. Tell your physician which questions you answered "Yes" to. After a medical evaluation, seek advice from your physician on what type of activity is suitable for your current condition.

Health History:

YES NO

1. Have you ever had any musculoskeletal pain, injury or surgery?

(Disc Problems, Arthritis, Tendonitis, Bursitis, Impingement, Joint Replacement etc.)
(If yes, please explain) Include: sports, auto, and work Injuries

2. Recent surgeries? (If yes, please explain)

3. Has a doctor ever diagnosed you with a chronic disease such as: Coronary heart disease, Emphysema, Cystic Fibrosis, Osteoporosis/Osteopenia, Fibromyalgia, Chronic Fatigue, MS, Hypertension, Diabetes, Thyroid Disease, or High Cholesterol? (If yes, please explain)

4. Asthma? (Do you carry an inhaler with you?)

5. Are you taking any medication? Including HRT, Fertility etc.
(If yes, please explain)

6. Pre Natal / Post Natal? C-Section(s)? How far along / ago? Please explain.
(Dr. release will be needed if pregnant)

7. Allergies (If yes, please list)

8. Scoliosis - Type of curvature

9. Smoker - Packs/Day:

10. Cancer-
Type:

Active or Remission:

If Remission, how long:

11. Is there any other condition that we may need to be aware of to safely engage you in an exercise program?

From the options below, please list your primary reason for visiting: PLEASE SELECT ONE

Please mark additional fitness goals:

- | | | |
|---|--|---|
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Abdominal/Lower Back Strength | <input type="checkbox"/> Stress Reduction |
| <input type="checkbox"/> Increase Flexibility | <input type="checkbox"/> Energy Gain | <input type="checkbox"/> Injury Recovery |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Gain Strength | <input type="checkbox"/> Improve Posture |

Other _____

Do you currently workout on a regular basis? Yes No

If yes, please describe your current workout program and the frequency:

Has any exercise program had any positive or negative effects on your body? (If yes, please explain)

Recreation/Hobbies:

Do you partake in any recreational activities? (If yes, please list)

- | | | | |
|--|---|----------------------------------|-------------------------------------|
| <input type="checkbox"/> Yoga | <input type="checkbox"/> Group Exercise | <input type="checkbox"/> Golf | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Martial Arts/Boxing | <input type="checkbox"/> Basketball | <input type="checkbox"/> Cycling | <input type="checkbox"/> Volleyball |
| <input type="checkbox"/> Tennis | <input type="checkbox"/> Pilates | <input type="checkbox"/> Skiing | <input type="checkbox"/> Dance |

I am aware that Marcy McCusker is here to serve me by sharing knowledge of Pilates and health. I understand that the practice of Pilates involves physical movement and exercise which may from time to time be strenuous and that such practice carries some risk of injury. I also understand that I must judge my own capabilities with respect to practicing Pilates with Marcy McCusker. By participating in classes or activities with Marcy, I agree to take full responsibility for not exceeding my limits in the practice of Pilates and for any injury I might suffer while in the practice of Pilates with Marcy. I acknowledge that it is my responsibility to inform Marcy immediately if an injury occurs during a class session. I understand from time to time during class Marcy might physically adjust my form. If I do not wish to be adjusted I will let Marcy know at the beginning of each class. I also acknowledge that if I do not wish to receive physical adjustments it is my responsibility to inform Marcy when an adjustment has gone as far as I wish at that time. I hereby waive and release any claim that I might have at any time for injury of any sort during the practice of Pilates against Marcy McCusker.

I have read, fully understand and agree to the above.

Date _____ Signature _____

If under 18 years of age:

As legal guardian of _____ we consent to the above conditions

Signature _____.