Contact Sheet

Today's Date: ____/____/____
Name: ____________________________________ Date of Birth: ____/____/____

Mobile Phone: _______________________ Home Phone: __________________
Work Phone: ________________________ Gender: M or F

Street Address: ____
City: _______________________________ State: ________ Zip: __________
E-mail: ____
Preferred communication: ☐ E-mail ☐ Cell Phone Call ☐ Cell Phone Text

Emergency Contact Information:
Name:___________________ Relationship: ____________Phone: ________________

How did you hear about our Studio? _________________
Whom can we thank for sending you our way? _______________

ACKNOWLEDGEMENT OF RISK & WAIVER OF LIABILITY

I understand that I will be participating in a fitness program through CORE Pilates & Yoga that will require physical exertion. Although the most common injuries or symptoms associated with exercises involve sprains, strains, dizziness, fainting and/or discomfort in breathing, I recognize that there is a risk of serious injury (and in extreme cases, death) associated with any fitness program. Consequently, I was advised by a member of the CORE Pilates & Yoga fitness team to obtain the approval of my doctor before beginning a fitness program through CORE Pilates & Yoga, and have had the opportunity to do so. Before beginning this program, I also was asked by a member of the CORE Pilates & Yoga fitness team, whether I have any physical and mental limitations, or whether I am taking any medications or receiving any medical treatment that might make is unsafe for me to participate in this fitness program. There are no such limitations, medication or medical treatment other than those I have written on the attached sheet.

I understand that by signing this statement, I am agreeing not to hold CORE Pilates & Yoga organization or any of its employees, owners, agents or insurers responsible for any bodily injury or property damage that I may suffer as a result of my participation in a fitness program through CORE Pilates and Yoga, whether at CORE Pilates & Yoga Studio, at home, or elsewhere. As such, I understand and agree that CORE Pilates & Yoga, its employees, owners, agents or insurers shall not be liable for any bodily injury or property damage that may result either directly or indirectly from my participation in a fitness program through CORE Pilates & Yoga.

Signature: ____________________________________ Date: ___/___/___

If under 18 years of age; Parent/Guardian name: ________________________________

Parent/Guardian Signature: ____

I understand there is a 12-hour cancellation policy in effect for all private training sessions and a 2-hour cancellation policy for all small group training classes. _______ Initials

Health History

Name: ____________________ Age: _____Gender: M / F Height: ____ Weight: _____

In order to design a safe and effective fitness program it is important that you complete the following Health History. It is crucial that you answer all the questions honestly and to the best of your ability. **Please be advised that all information is kept strictly confidential.**

A. Check the appropriate response. *Read all questions thoroughly*.

Yes	No	
☐	☐	Has a doctor ever told you that you have heart problems?
☐	☐	Has a doctor ever told you that you have high blood pressure?
☐	☐	Have you ever suffered a stroke?
☐	☐	Have you ever suffered a heart attack?
☐	☐	Have you ever had pain in your chest?
☐	☐	Do you ever feel faint or have dizzy spells?
☐	☐	Have you had surgery in the last six months?

B. Circle any conditions you may currently have.
Diabetes Seizures High Blood Pressure Cancer Pregnancy Asthma Arthritis
Heart Problems Osteoporosis Other: _________________________

C. Have you injured or have pain in the following areas? (**Circle all that apply**.)
Neck Upper Back Shoulders Elbows Hips Wrists Knees Lower Back

If circled, please explain. ____

____

D. Are you currently taking any medications? YES NO
If you circled "Yes", please list the medications, dosage, and for what condition.
Medication _____________ Dosage _______ Condition_________________
Medication _____________ Dosage _______ Condition_________________
Medication _____________ Dosage _______ Condition_________________

E. Are you currently undergoing treatment from any of the following? **(circle)**
Physical Therapist Chiropractor Massage Therapist *If Yes, why?* ____________________________________

F. What is your current exercise level? **(circle)**
None 2 – 3 times/week 4 – 5 times/week *Please Describe:* ____

G. How would you rate your level of stress on a daily basis? **(circle)**
Low 1 2 3 4 5 High

H. Job/School/Activities on a Daily Basis: ____

I. What are your exercise goals? **Number the following exercise benefits according to their importance to you. (1 being the most important)**
Weight Loss ___ Weight Gain ___ Stress Reduction ___ Cardiovascular Conditioning ___
Flexibility/Balance ___ Posture ___ Increase Strength ___ Other: ______________________

J. Estimate how many hours of sleep you get each night. ______________________

K. Do you currently smoke or use tobacco products? Yes No *If yes, please note frequency:* _________________

L. What type of beverage do you consume on a regular basis? _______________ *note frequency:* _________________

M. Do you consume 4 or more servings of fruits and vegetables each day? Yes No
Note Any Dietary Concerns:____

N. Are there any other reasons (health or personal) that may limit or prevent you from exercising?
____

Please be advised that certain health restrictions may require you to obtain medical clearance from your physician.