Health and Fitness History

Synergy Studio

Please fill out this form to the best of your ability and sign at the bottom of the form. If you have any questions please feel free to ask.

Name: _____ Birth date: _____ Date: _____

Address: _____

Street City Zip Code

Home Phone: _____Work Phone: _____Cell Phone: _____Email: _____

Employer: _____Occupation:_____

How long is your work day?_____ Is your job physically or mentally demanding?_____

Sex: M/F Marital Status:_____ General Health: _____Excellent _____Good _____Fair _____Poor

Previous experience with Pilates:_____

Personal Goals:_____

Medications:_____

Previous Injuries:_____

Previous Surgeries:_____

Are you currently experiencing any physical problems? If so, please explain: _____

_____

Are you currently receiving professional health care services? If so, please explain: _____

_____

Date of you last doctor's visit: __ _____Do you smoke? Yes/No If yes, how much? _____

Has your doctor indicated any limitations or exclusions of certain activities? Describe: _____

_____

Are you currently or have you previously been diagnosed with any of the following?

Arthritis	Yes	No	Herniated Disc	Yes	No
Back Pain	Yes	No	High Blood Pressure	Yes	No
Cancer	Yes	No	Hypoglycemia	Yes	No
Carpal Tunnel Syndrome	Yes	No	Numbness	Yes	No
Circulatory Disease	Yes	No	Osteoporosis	Yes	No
Diabetes	Yes	No	Pelvic Floor Pain/Weakness	Yes	No
Dizziness	Yes	No	Pregnancy	Yes	No
Fainting	Yes	No	Seizure Disorder	Yes	No
Fibromyalgia	Yes	No	Shoulder Impingement	Yes	No
Heart Disease	Yes	No	Stenosis	Yes	No

How did you hear about us? _____

Is there anything that you feel we should know and have not asked? If so, please explain: _____

_____

I, THE UNDERSIGNED, DO HEREBY CERTIFY THAT I HAVE COMPLETED THE ABOVE INFORMATION AND KNOW IT TO BE TRUTHFUL AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____DATE: _____