



Personal Information

Name _____ Date ____/____/____
 _____/____ How did you hear about us? _____
 Email _____ Local _____
 Address _____ City _____ State _____
 Zip _____ Home Phone (____) _____ Cell Phone (____) _____
 Work (____) Age _____ Gender _____ DOB ____/____/____
 Height _____ Weight _____ Emergency Contact _____
 Occupation _____ Hours spent standing/sitting daily _____

Health History

Physician's Name _____ Phone (____) _____
 _____ Date of last medical exam? ____/____/____ Were the results normal?
 ____ Yes ____ No Do you have doctor's clearance to exercise? ____ Yes ____ No Do you take
 any medications? ____ Yes ____ No If yes, please list medication(s) and reason(s) for
 taking: _____ Are you currently involved in a
 regular exercise program? ____ Yes ____ No If yes, please list activity, duration, frequency and
 intensity: _____ Have you tried Pilates before?
 ____ Yes ____ No If yes, where and what type of session (ex: group mat class, private eqpt
 training): _____

Medical History

Please check any condition you have or have had:
 _____ Heart Attack, Coronary Bypass, Cardiac surgery _____ Diabetes _____ Stroke _____ Peripheral
 vascular disease _____ Phlebitis, emboli _____ Rheumatic fever _____ High blood pressure _____ Low
 blood pressure _____ Chest discomfort _____ Extra, skipped or rapid heart beats _____ Hear murmurs
 _____ Ankle swelling _____ Fatigue, lack of energy _____ Cold hands or feet _____ Arthritis _____ Foot
 problems _____ Ulcers _____ Back problems _____ Neck problems _____ Shoulder problems
 _____ Pneumonia _____ Swollen, stiff or painful joints _____ Stomach or intestinal problems _____
 Migraine or recurrent headaches _____ Hernia _____ Bursitis _____ Limited range of motion in joints
 _____ Lightheadedness or fainting _____ Unusual shortness of breath _____ Epilepsy, seizures _____
 Emotional disorders _____ Trouble sleeping _____ Increased anxiety or depression _____ Chronic
 recurrent cough _____ Bronchitis _____ Broken bones _____ Knee problems _____ Anemia _____
 Asthma _____ Emphysema _____ Osteoporosis _____ Osteopenia
 If you checked any of the above, please provide
 details: _____
 Please describe any other physical limitations you have that may affect your Pilates exercise program:



Studio Policies

Session Payment:

I understand that all sessions must be paid in advance in order to hold my place in a scheduled class, semi-private, or private session and a \$20 late fee applies. _____

Courtesy Policy:

I will turn off my cell phone before entering the studio and will respect other classes and sessions going on by keeping my voice low while talking to other clients. _____

Refund Policy:

I understand that upon payment of a single session or series package of classes, no refund will be granted if I choose not to use pre-paid classes. _____

Waiver of Liability

Precision Pilates Studio

I, the undersigned participant in this exercise class, as a condition of my participation, hereby waive any and all claims I may have now or in the future against my instructor, Megan Stokes and Precision Pilates Studio, in connection with or arising out of my participation with this exercise class or any injury to myself related hereto.

I understand that any exercise program carries with it some risk and acknowledge that risk. I have consulted with my Dr and she/he agrees that this exercise program is appropriate for my current state of health.

Signature _____

Date

960 Tunnel Road
Asheville, NC 28805
828.774.5575
www.precisionpilatesavl.com
info@precisionpilatesavl.com