Name________________________________
Address ______________________________
City____________ Zip___________
Phone - mobile_______________
Home_____________ Work ____________
Email _____________________________

Last Name, First Name

Birth date ______________ Age ___
Physician's Name ______________________ Phone number ___________
Emergency Contact _____________________ Phone Number ___________
How did you learn about Triangle Pilates? **__________________________________**
What is your short-term (2 month) goal? ____________________________________

1. **Do you smoke (if yes indicate quantity)? ______________________**
2. **Has your doctor ever said that your blood pressure was too high or too low?**
   ____
3. **Have you (or a family member) ever been told that you have diabetes? ____**
4. **Do you have any known cardiovascular problems (abnormal ECG, previous heart attack, etc.)? ____**
5. **Have you lost any family members due to a heart attack or other sudden death (please explain and include age at death)? ______________________**
   ____
6. **Has your doctor ever told you that your cholesterol level was too high?**
   ____
7. **Do you have any injuries or orthopedic problems (bursitis, bad back, bad knees etc.) that could be made worse by exercise – please be specific? ____**
   ____
   ____
8. **Please list (on the back if needed) any prescribed medications or dietary supplements that you are taking? ___________________________________**
9. **Are you pregnant or post-partum less than six weeks? _________________**
10. **Date of last physical examination. ___________________________________**
11. **Do you often feel faint or have spells of severe dizziness? _______________**
12. **Do you experience extreme breathlessness after mild exertion? __________**
13. **Has your doctor ever said that you have bone or joint problems, such as arthritis, that can be aggravated or made worse by exercise? _____________**
14. **Do you have any other medical conditions or problems not previously mentioned? ____**
    ____

I acknowledge, to the best of my ability, that I am in good health and have no known medical problems that would restrict my ability to participate in this exercise program. I will notify the instructor if I am made aware of changes to this history.

Signed _____________________________________ Date _________

OFFICE USE input complete ____ class attending_____________ pmt rec'd___________
referral checked ___