



Health History  
(Please Print Legibly)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**Thank you for providing this confidential information, which will help us instruct you safely and to advance and modify your personal exercise program as appropriate. (Please Circle)**

Have you had a recent medical evaluation? Yes No Were the results satisfactory?

Yes No If no, please explain: \_\_\_\_\_  
\_\_\_\_\_

Have you had any traumatic injuries? Yes No If yes, please give date and occurrence: \_\_\_\_\_  
\_\_\_\_\_

Have you had past surgeries, illnesses, or accidents that impact your ability to work out?

Yes No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Do you experience tension or pain or difficulties? Joint issues? Yes No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Where does it hurt? Neck Back Knees Breathing

Have you been diagnosed with osteoporosis? Yes No If yes, what grade was identified and where? \_\_\_\_\_  
\_\_\_\_\_

List physical activities you **currently** engage in: \_\_\_\_\_  
\_\_\_\_\_

Present health concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any prescription and non-prescription medicines, vitamins, home remedies, etc., you may currently be taking: \_\_\_\_\_  
\_\_\_\_\_

Do you currently have any food or other allergies (e.g., latex)? Yes No If, yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Do you have a history of or currently suffer with migraine headaches? Yes No

Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis):

_____ Congenital heart disease; specify type _____ _____	_____ Cancer (malignancy); specify type _____ _____	_____ Stroke _____ Alcoholism _____ Abnormal PAP smear
_____ Myocardial infarction (heart attack)	_____ Coagulation disorder (bleeding/clotting disorder)	Other problems: _____ _____
_____ Hypertension (high blood pressure)	_____ Thyroid problem; specify type _____	_____
_____ Diabetes	_____ Depression/Suicide attempt	_____
_____ High cholesterol		
_____ Sleep disorders; specify type _____		

Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis):

Operation	Date	Operation	Date

Do you currently or have you ever used tobacco products? Yes No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Are there any other issues you would like to bring to our attention? \_\_\_\_\_  
\_\_\_\_\_

## WAIVER OF LIABILITY AND INFORMED CONSENT RELEASE

Consultation with a medical practitioner is recommended prior to beginning any program of regular exercise. I understand this exercise and conditioning program, like any physical conditioning activity or exercise program, presents some unavoidable risk of injury, especially to people who have pre-existing injuries, illness or medical disabilities. I further understand the use of exercise equipment also carries a risk of injury.

I have, and will continue to keep Gigi's Pilates Studio, LLC, fully informed of any physical condition or disability that would prevent or limit my participation in an exercise or physical conditioning program. I acknowledge that, although the conditioning program I participate in may have substantial physical benefits, neither Gigi's Pilates Studio, LLC, nor its employees or its independent contractors, are engaged in diagnosing or treating medical diseases or deficiencies. I expressly assume all risk of my participation in the special exercise program conducted by Gigi's Pilates Studio, LLC, and waive any claim I might otherwise bring against Gigi's Pilates Studio, LLC, its officers, directors, employees, trainers, and contractors as a result of injury resulting from or relating to my participation in this special exercise program.

## MEDICAL RELEASE FOR KRUSH CLIENTS ONLY

I certify that \_\_\_\_\_ has consulted with a licensed medical professional (e.g., a licensed physician or surgeon, a qualified doctor of chiropractic, a qualified physician's assistant) and **medical clearance for full and unlimited participation** in the Gigi's Pilates Studio & Personal Training KRUSH fitness program is given.

\_\_\_\_\_  
Licensed Professional's Name (PRINT)

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Licensed Professional's Signature

\_\_\_\_\_  
Date

## STUDIO POLICIES

**Welcome to Gigi's Pilates Studio & Personal Training.** Please take a minute to read our studio policies thoroughly. We are honored that with all of your exercise options you have selected our studio. Thank you very much! We hope your experience with our instructors will be fun, rewarding, and beneficial to your health and fitness.

These policies are designed to ensure you have a successful training experience. Please read these policies carefully and direct any questions to your instructor today, or to the Gigi's Pilates Studio & Personal Training management team.

Please read the following and initial each line **ONLY** if you do not have any questions.

\_\_\_\_\_ **LATE ARRIVALS:** Our instructors are frequently scheduled into consecutive sessions, therefore, if you arrive late, lost time will not be made up at the end of your session.

\_\_\_\_\_ **CANCELLATIONS:** To avoid being charged, 24-hour notice is required for ALL scheduled appointments.

\_\_\_\_\_ **STANDING APPOINTMENTS:** Time slots can be guaranteed with purchased packages. Inconsistent attendance, less than 90 percent use may result in the loss of a standing appointment time slot, regardless of 24-hour notice.

**All sessions and classes purchased are NON-REFUNDABLE and EXPIRE 365 days/one year after purchase.**

\_\_\_\_\_

Name (PRINT)

\_\_\_\_\_

Date

\_\_\_\_\_

Your Signature or Parent/Guardian If Under 18

\_\_\_\_\_

Date