



Contact details

Name _____

Address _____

City/town _____

Province _____ Postal code _____

Tel [home] _____

Tel [cell] _____ tel [work] _____

Email _____

How did you hear
of Studio Praxis?

Personal information

In an effort to provide you with the **best possible care and service**, we ask that you carefully **fill out** the following information. This information is kept **strictly confidential** and will not be accessible to anyone other than your trainer and the studio coordinator.

Date of birth _____

Physician _____

Physician's telephone _____

Date of last physical exam _____

Other health care providers _____

Emergency contact _____

Relation _____

Emergency contact telephone _____

Declaration I, _____ hereby state that the information provided to Studio Praxis Inc. is truthful and complete. I recognize that failure to disclose important medical information releases Studio Praxis Inc and its trainers, staff and associates from all liability. I agree to keep Studio Praxis Inc. updated as to any changes in my health status.

Signature: _____

Date: _____

(praxis)



Please identify **all conditions that apply:**

	Yes • No			Yes • No	
Cardio-Respiratory			Musculo-Skeletal		
1 Current heart disease angina, arrhythmias, heart failure, etc.	<input type="radio"/>	<input type="radio"/>	1 Left Handed Right Handed	<input type="radio"/>	<input type="radio"/>
2 Family history of CHD	<input type="radio"/>	<input type="radio"/>	2 Orthotics	<input type="radio"/>	<input type="radio"/>
3 History of stroke or TIA	<input type="radio"/>	<input type="radio"/>	3 Osteoarthritis or rheumatoid arthritis	<input type="radio"/>	<input type="radio"/>
4 Heart murmur or mitral valve prolapse	<input type="radio"/>	<input type="radio"/>	4 Osteopenia or osteoporosis	<input type="radio"/>	<input type="radio"/>
5 Heart Palpitations	<input type="radio"/>	<input type="radio"/>	5 Injuries and falls	<input type="radio"/>	<input type="radio"/>
6 Hypertension	<input type="radio"/>	<input type="radio"/>	6 Concussion or head trauma	<input type="radio"/>	<input type="radio"/>
7 Elevated blood pressure during pregnancy	<input type="radio"/>	<input type="radio"/>	7 Motor vehicle accident	<input type="radio"/>	<input type="radio"/>
8 Elevated cholesterol	<input type="radio"/>	<input type="radio"/>	8 Surgeries or scars	<input type="radio"/>	<input type="radio"/>
9 Deep vein thrombosis or blood clots	<input type="radio"/>	<input type="radio"/>	9 Any other restrictions to mobility If yes please list:	<input type="radio"/>	<input type="radio"/>
10 Varicose veins	<input type="radio"/>	<input type="radio"/>	10 Neck/cervical spine injuries, pain or discomfort	<input type="radio"/>	<input type="radio"/>
11 Any other cardiac or circulatory problems	<input type="radio"/>	<input type="radio"/>	11 Shoulder injuries, pain or discomfort	<input type="radio"/>	<input type="radio"/>
12 Medications	<input type="radio"/>	<input type="radio"/>	12 Arm, elbow & wrist injuries, pain or discomfort	<input type="radio"/>	<input type="radio"/>
13 Do you smoke?	<input type="radio"/>	<input type="radio"/>	13 Back injuries, pain or discomfort	<input type="radio"/>	<input type="radio"/>
If so, how many per day? _____			14 Sciatica or any other neurological conditions	<input type="radio"/>	<input type="radio"/>
14 Do you experience shortness of breath?	<input type="radio"/>	<input type="radio"/>	15 Disc bulge or herniation	<input type="radio"/>	<input type="radio"/>
15 Are you more than 30 lbs overweight?	<input type="radio"/>	<input type="radio"/>	16 Hip/groin injuries, pain or discomfort	<input type="radio"/>	<input type="radio"/>
16 Asthma	<input type="radio"/>	<input type="radio"/>	17 Knee injuries, pain or discomfort	<input type="radio"/>	<input type="radio"/>
If yes please list medications: _____			18 Ankle & foot injuries, pain or discomfort	<input type="radio"/>	<input type="radio"/>
_____			19 Have you ever received physiotherapy or any other physical therapy?	<input type="radio"/>	<input type="radio"/>
17 Frequent colds, bronchitis	<input type="radio"/>	<input type="radio"/>	If yes please list type: _____		

18 Any other chronic lung disorder(s)	<input type="radio"/>	<input type="radio"/>	Pregnancy		
If yes please list: _____			Have you ever been pregnant? If so, how many pregnancies? _____		
_____			Are you currently pregnant or trying to become pregnant? <input type="radio"/> <input type="radio"/>		
			Please list any conditions related to your pregnancies (gestational diabetes, hypertension, diastasis recti etc...)		

General Medical			Medications and Supplements		
1 Fainting or Dizziness	<input type="radio"/>	<input type="radio"/>	Please list any and all medications that you are currently taking:		
2 Epilepsy	<input type="radio"/>	<input type="radio"/>	_____		
3 Migraines	<input type="radio"/>	<input type="radio"/>	Please list any and all supplements and vitamins that you are currently taking:		
4 Tension or cluster headaches	<input type="radio"/>	<input type="radio"/>	_____		
5 Corrective lenses – glasses and/or contact lenses	<input type="radio"/>	<input type="radio"/>			
6 Diabetes	<input type="radio"/>	<input type="radio"/>	Activity History		
If yes, type: _____			_____		
insulin: _____			Occupation		
7 Complications related to diabetes? (retinopathy, neuropathy, kidney dysfunction)	<input type="radio"/>	<input type="radio"/>	_____		
8 History of gestational diabetes	<input type="radio"/>	<input type="radio"/>	Sports and activities since childhood		
9 Allergies	<input type="radio"/>	<input type="radio"/>	_____		
If yes please list: _____			Current sports and activities		
_____			_____		
10 Thyroid problems	<input type="radio"/>	<input type="radio"/>	Goals		
11 Gastrointestinal disorders	<input type="radio"/>	<input type="radio"/>	_____		
12 Kidney disease	<input type="radio"/>	<input type="radio"/>	What do you hope to achieve through pilates?		
13 Any other medical conditions not listed	<input type="radio"/>	<input type="radio"/>	_____		
If yes please list: _____			What are your general health objectives?		
_____			_____		
14 Have you ever consulted a dietitian?	<input type="radio"/>	<input type="radio"/>			