PILATES BY VAL, INC.
REGISTRATION AND MEDICAL HISTORY

Name:____**Today's date**_____________

Address:____

City_______________________________________**Zip**___________**DoB**_____________

Cell phone:____________________**email**_______________________________________

Emergency contact:________________________________**Phone:**___________________

Please circle any of the following that apply to you:

high blood pressure	heart problems	cancer
diabetes	joint problems	pregnancy
liver disease	fractures	chronic illness
night pain	seizures	asthmas
shortness of breath	recent surgery	smoker
osteoporosis	back problems	scoliosis
knee problems	arthritis	difficulty with exercise

Please give any details for the conditions circled above:

Current therapy and do you have Dr. approval to exercise?:

Current medications:

1.
2.
3.
4.
5.
6.

How did you hear about us?