KINESPIRIT CIRCLE

Personal Information

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____ Email: _____

Date of Birth: _____ Age: _____ Height: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

How did you hear about us? (Please check all that apply)

- ☐ Google
- ☐ Bing
- ☐ Yahoo
- ☐ Facebook
- ☐ City Search
- ☐ Explore the Pearl
- ☐ Postcard
- ☐ Walk by
- ☐ Referral _____
- ☐ Other _____

Goals

Describe any lifestyle behaviors or health/physical goals that you would like to achieve:

_____

_____

_____

Health/Background

Have you taken a Pilates or GYROTONIC® class before (circle one)? *Yes / No*

If yes, please explain past experiences including length of experience, instructor, & type of class:

_____

_____

Do you currently exercise (circle one)? *Yes / No*

If yes, describe your current regimen:

_____

_____

Do you have any concerns about your current exercise regimen (circle one)? *Yes / No*

If yes, please explain:

_____

_____

Do you have any present or past injuries or ongoing conditions that impact your ability to exercise (circle one)? *Yes / No*

If yes, please explain:

_____

_____

Are you currently under a health provider's care (circle one)? *Yes / No*

If yes, for what reason, and are there any restrictions on your ability to exercise?

_____

_____

Are you currently taking medications or nutritional supplements? Please identify so we can assess any impact on your ability to perform Pilates or GYROTONIC®.

_____

_____

_____

Please mark below and describe, if necessary, any condition you have experienced, are presently experiencing, or have had recent treatment for. Indicate whether it is a past (P) or current (C) condition and date:

Cancer: ☐No ☐Yes: P/C _____

Pregnancy: ☐No ☐Yes: P/C _____

Smoker: ☐No ☐Yes: P/C _____

Heart Attack/Cardiac Condition or Disease: ☐No ☐Yes: P/C _____

Diabetes: ☐No ☐Yes: P/C _____

High Blood Pressure: ☐No ☐Yes: P/C _____

Depression/ Mental Illness: ☐No ☐Yes: P/C _____

Orthopedic Problems: ☐No ☐Yes: P/C _____

Auto Immune Disorder: ☐No ☐Yes: P/C _____

Chronic Pain (describe below): ☐No ☐Yes: P/C _____

_____

Surgery (describe below): ☐No ☐Yes: P/C _____

_____