



KarMel Pilates

Votre passage au bien-être

Your path to well being

HEALTH EVALUATION

NAME: _____

ADDRESS: _____

CITY: _____

PROVINCE: _____ POSTAL CODE: _____

TELEPHONE: _____ CELLULAR: _____

How did you here about Karmel Pilates? _____

(all information provided is strictly confidential)

Date of birth: _____

Family Physician: _____

Telephone: _____

Date of last check up: _____

Emergency contact: _____

Employment: _____

Present activities: _____

Goals expected from Pilates: _____

I, _____ hereby state that the information provided to Karmel Pilates Inc. is truthful and complete. By agreeing to this registration form, I, myself assume all risks associated with participation in this activity including, but not limited to falls, contact with other participants, the effects of weather, equipment, condition of facilities, all such risks being known and appreciated by me. I acknowledge that it is strongly recommended to consult a physician before beginning any fitness program. Having read this waiver and knowing these facts, I, and anyone who acts on my behalf, waive and release Karmel Pilates and their representatives and successors from all claims or liabilities of any kind arising out of my participating or my child (children) in this activity even though that liability may arise out of negligence or carelessness on the part of the persons named in this waiver. I have read and understand the above waiver of participation. In addition, my acceptance of this waiver signifies my permission that any photographs taken while participating in activities at the Karmel Pilates will become property of Karmel Pilates will and may be used in published materials.

Signed _____ Date: _____

www.karmelpilates.com

19H Centre Commercial, Roxboro, QC H8Y 2N9

T 514 676 1407

E info@karmelpilates.com



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	YES	NO
Cardiac problems	___	___
Hypertension	___	___
Are you pregnant	___	___
High Cholesterol	___	___
Varicose veins	___	___
Circulation problems	___	___
Medications / supplements / vitamins	___	___
Which ones _____		
Do you smoke?	___	___
Asthma	___	___
Bronchitis	___	___
Dizziness/ Fainting	___	___
Epilepsy	___	___
Migraines	___	___
Diabetes	___	___
Allergies	___	___
Thyroid	___	___
Osteo/ Arthritis	___	___
Medical restriction	___	___
Other problems? _____		

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