



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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24-Hour Cancellation policy

To avoid being charged for missed not classes, we require a full 24-hours notice.
This is a standard requirement in small studios and
Clinics. It is vital for the good function of the studio and those who use it.

Signature: _____

Date: _____

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