Joe's Place
TRUE PILATES

Client Registration

Full Name: _____ Date: _____

Is there a nickname you prefer us to use? _____

Cape Cod Mailing Address _____

City and State _____ Zip Code _____

**Please indicate dates residing at Cape Cod address: _____

Off-Cape Mailing Address (if applicable) _____

City and State _____ Zip Code _____

**Please indicate dates residing at off-Cape address: _____

E-Mail _____

Would you like to be included in mailings or e-mailings of newsletters or specials? Yes _____ No _____

Phone Numbers: Home _____ Work _____

Cell _____ Other _____

Please tell us how you heard about Joe's Place-True Pilates: _____

Your Age _____ Your Birthdate _____/_____/_____ ***Your age and birth year are always kept confidential.***

Your Height _____ Your Weight _____ Do you have weight loss goals? _____ Desired Weight _____

What is your Primary Health & Fitness Goal? _____

Your Occupation _____

Emergency Contact: Name _____ Relationship _____

Phone Numbers: Home _____ Work _____ Cell _____

Physician's Name and Location: _____

Has your physician approved your participation in a fitness program? Yes_____ No_____

Do you exercise (please list activities and how often)? _____

_____

Other than your current exercise activities, what types of movement/training/workouts have you experienced?

___Pilates ___Yoga ___Dance ___Group Fitness ___Weight Training ___Other: _____

Are you currently receiving any physical therapy or medical care? _____

Please advise us of any medications/supplements you are taking: _____

Please list any medical conditions, surgeries, accidents, bone, joint or muscle diseases or injuries, or any other condition or physical limitations that might make it unsafe for you to participate, or limit your participation in this program:_____

_____

Any allergies? _____

Is there anything else we should know about you?_____

_____

_____

_____

_____