

INTEGRATED HEALTH CARE AND FITNESS STUDIO

577 Ontario Street St. Catharines, ON L2N 4N4.

•Tel: (905) 988-9160 Fax (905) 988-9147

STUDENT PROFILE

NAME _____ AGE _____ BIRTHDATE _____

ADDRESS _____ CITY _____ POSTAL CODE _____

PHONE (Home) _____ (Work) _____

E-mail Address: _____

OCCUPATION _____ EMPLOYER _____

EMERGENCY CONTACT _____ RELATION _____

CONTACT NUMBER _____

How did you find out about our studio? _____

YOUR HEALTH HISTORY

What is your current level of energy from 1 to 10 (where 10 is the best you have ever felt)? _____

Which of the following conditions apply to you? Please indicate if **NOW** (N) or in the **PAST** (P).

	N	P		N	P		N	P		N	P
Allergies			Weight problems			Stroke			Venereal disease		
Asthma			Gallstones			Cancer			Syphilis		
Eczema			Gout			Epilepsy			Gonorrhea		
Psoriasis			Arthritis			Migraine			Miscarriage		
Ear infections			Thyroid problems			Pneumonia			Varicose veins		
Strep throat			Anemia			Diabetes			Broken bones		
Hay fever			High blood press.			Malaria			Numbness/tingling		
Measles			Rheumatic fever			Tuberculosis			Cold hands/feet		
Mumps			Fainting			Small pox			Warts		
Chicken pox			Poor memory			Polio			Mono		
Whooping cough			Balance problems			Gas/bloating			Depression		
Diphtheria			Speech problems			Hemorrhoids			Yeast infection		
Scarlet fever			Ringing in ears			Parasites			Mental illness		
Sinusitis			Jaundice			Rectal bleeding			Child abuse		
Canker sores			Hepatitis			Herpes			Physical abuse		
Acne			Heart disease			Headaches			Sexual abuse		
Tonsillitis			Alcoholism			Visual problems			Emotional abuse		

Other:

Are there any of these from which you feel you have never been well since?

Do you have any allergies to drugs, herbs, foods, or other? If so, please specify:

Have you had any major injuries, previous surgeries and hospitalizations? If so, what happened and when?

Is there anything that could interfere or be affected by engaging in exercise classes? If so, please list and advise your instructor so that modifications can be made for you:

Are you pregnant? _____ Have you recently given birth? ____ If so, when? _____

What types of exercise have you experienced:

___ Dance ___ Yoga ___ Pilates ___ Zumba ___ Weight training ___ Running
___ Martial Arts ___ Swimming ___ Aerobics ___ Sports (list: _____)
___ None ___ Other (please specify) _____

What are your fitness goals? Please explain:

Thank you! We hope that you enjoy your classes with us!