

CLIENT INFORMATION

Last Name:	First Name:	M.I.:	DOB:	<input type="checkbox"/> Male:	<input type="checkbox"/> Female:
Street Address:	City/State:	Zip Code:	Home Phone:	Cell Phone:	
Occupation:	Employer:	Employer Address:		Work Phone:	
Emergency Contact:		Relationship::		Phone:	

Number and Ages of Children: _____

Hobbies/Recreational Activities and Frequency: _____

Previous Pilates Experience: _____

Personal Goals: _____

General Health: Excellent Good Fair Poor

Are you currently experiencing any physical problems? If so, please explain: _____

Are you currently receiving professional health care services (i.e. Chiropractic, Medical, Massage, Physical or Occupational Therapy)? If so, please explain: _____

Please list all current medications (prescription, over the counter, or supplements): _____

Please list all allergies (medication or food): _____

Medical History: Have you been diagnosed or treated for any of the following. List current and post medical conditions, even if they have resolved:

- | | | |
|---|---|---|
| <input type="checkbox"/> Arthritis/Joint Pain | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Back Pain/Spine Disorder | <input type="checkbox"/> Heart Disease - BP | <input type="checkbox"/> Pulmonary Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Diabetes/Metabolic Disease | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Shoulder Impingement |
| <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Numbness or Weakness | <input type="checkbox"/> Stenosis |
| | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |

Other: _____

Please list all past surgeries (i.e. tonsillectomy, appendectomy, gall bladder, C-section, hernia, etc.)

Year	Surgery	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Smoking History (please check one):

- Yes; ____ packs per day for ____ years
- No quit in ____ (year) but previously smoked ____ packs per day for ____ years
- No never

Anything else you would like us to know that has not been asked: _____

I, THE UNDERSIGNED, DO HEREBY CERTIFY THAT I HAVE COMPLETED THE ABOVE INFORMATION AND KNOW IT TO BE TRUTHFUL AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____

DATE: _____