CLIENT INFORMATION FORM

First Name: _____ Last Name: _____

Gender: (circle) Male or Female Date of Birth: _____

Home Address: _____

City: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Emergency Contact Name/Relation: _____

Emergency Contact Phone: _____ Would you like to receive our newsletter:(circle) Yes No

Email Address: _____

How did you hear about us? _____

What is your current activity/exercise level? _____

Please tell us about your Pilates Experience/Goals: _____

Have you ever been treated by a Physician for: (circle all that apply)

Arthritis	Chronis Fatigue Syndrome	Gastric Reflux	Muscle Cramps
Fibromyalgia	Facet Joint Syndrome	Herniated Disc	Fractures
Glaucoma	Heart Disease	Joint Problems	Asthma
High Blood Pressure	Hip Replacement	Sponsylolisthesis	
Bulging Disc	Multiple Sclerosis	Peripheral Neuropathy	
Stenosis	Osteoporosis	Scoliosis	
Rheumatoid Arthritis	Diabetes	Vertigo	

Other: _____

Back pain? Please describe: _____

For Women, Are you pregnant? (circle) Yes or No

Please list any and all previous surgeries, any fractures and or injuries, and all trama (even minor): _____

_____

Cancer? Please Describe: _____

Are you, have you been active in any sports, physical activity, please describe? _____

_____

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

CLIENT SIGNATURE: _____ DATE: _____