PILATES movement studio

Name:

Address:

Date: Birthdate:

Email address:

Home Phone: Cellphone:

Emergency Contact: Cellphone:

Occupation:

How did you hear about us?

Do you have any injuries (Recent or past)? Please describe:

Do you have osteoporosis or Osteopenia?
If yes, do you know your T-score?

Please Circle any of the following that apply:

High Blood Pressure	Heart Problems	Post-Partum	Neurological	Diabetes
Joint Problems	Seizures	Respiratory	Pregnant	Recent Surgery
Medications	Scoliosis	Back Problems	Arthritis	Chronic Illness

Please Explain:

Are you currently doing other types of therapy(massage, physical therapy, chiropractic etc)?

Are you active in sports, exercise programs or other physical activities?

Have you ever done Pilates? If so, where?

What are your goals? What do you want to achieve with this program?