Contact Information:

Name: _____ Age: ____
Sex: M/F (circle)

Address: _____

_____

Home telephone number: _____
Work telephone number: _____
Cell phone number: _____
Email address: _____

Name of emergency contact: _____
Telephone number: _____ Relationship to you: _____

Medical History (please mark "p" for previous or "c" for current conditions):

headaches ____	TMJ ____	reflux ____
allergies ____	sprains ____	infectious diseases ____
tendonitis/bursitis ____	digestion difficulty ____	pregnancy ____
osteoporosis/osteopenia ____	diabetes ____	dizziness/vertigo ____
sinus issues ____	back pain ____	sciatica ____
shoulder pain ____	hypoglycemia ____	asthma ____
neck stiffness ____	eye pain/strain ____	arthritis ____
wrist pain ____	hand pain ____	high/low BP ____
carpal tunnel syndrome ____	numbness/tingling ____	knee pain ____
ankle pain ____	hip pain ____	heart problems ____

other (please specify) _____

List any physical limitations: _____
_____

List any medications you are currently taking: _____
_____

Have you had any of the following? (Please list with dates and descriptions)
Surgeries: _____
Broken bones: _____
Torn muscles: _____
Physical therapy: _____

General Health and Lifestyle:

Are you presently engaged in any type of exercise? ____ If so, please specify:

_____

Do you have any experience with Pilates? ____ If so, please specify: _____
With whom and for how long? _____
Would you consider yourself a beginner, intermediate or advanced student? _____

Is your present health status poor, average or very good? _____

Please list both your short term and long term fitness goals: _____

_____

Signature: _____ Date: _____