



Client Information

Name _____ Phone () _____
___ Male ___ Female DOB _____
Address _____
City _____ State _____ Zip _____
E-mail: _____
Referred by: _____
In case of emergency: _____
Phone () _____

Please take a moment to carefully read the following information and sign where indicated.

Have you had done Pilate’s previously? Yes No
How recently? _____ Where? _____ Private or Group _____
What are your Pilates goals? _____

If you answer “yes” to any of the following questions, please explain as clearly as possible.

- Yes No Are you pregnant?
- Yes No Do you frequently suffer from stress?
- Yes No Do you have diabetes? Yes No Have you ever had surgery? Explain below.
- Yes No Do you experience frequent headaches? _____
- Yes No Do you suffer from arthritis? Yes No Any injuries in the past 2 years?
- Yes No Do you suffer from joint swelling? _____
- Yes No Do you have osteoporosis? _____
- Yes No Do you have tension or soreness in a specific area? _____
- Yes No Do you suffer from back pain? Yes No Any broken bones in the past two years?
- Yes No Do you have numbness or stabbing pains? _____

Any other medical conditions I should be aware of _____

I understand that Pilates should not be construed as a substitute for medical examination diagnosis, or treatment. I affirm that I have stated all my known medical conditions and answered all questions honestly. I am aware that there is a 24 hour cancellation policy and that payment is due at time of service.

Client Signature _____

Date _____

