Client Profile and Medical History

Name_______________________________________Sex____Date of Birth____________

Street Address__________________________City__________State________Zip__________

Phone______________________Email Address__________________________________

Emergency Contact and phone
number____

Occupation___________________________How did you hear about us? ________________

Have you ever had: (please circle all that apply)

High Blood Pressure	Heart Problems	Joint Problems	Diabetes
Whiplash	Surgery	Cancer	Liver Disease
Asthma	Sprain	Fractures	Spine Disorders

Please explain:

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Chronic Illinesses: ____

What type of movement have you experienced: (please circle all that apply)

Running Swimming Aerobics Tennis Golf Soccer Volleyball

Weights Football Basketball Martial Arts Ballet Yoga Other

Are you pregnant: No Yes

Medications you are now taking: ____

Are you receiving care?

Physical Therapy – Therapist's name___________________Phone________________

Chiropractic – Dr.'s name___________________________Phone________________

What are your goals with Pilates? ____

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