



Client Profile and Health History

Name: _____ Age: _____

Address: _____ City: _____

Zip: _____ E-mail: _____

Cell Phone: _____ Home or Work Phone: _____

Profession: _____

Referred by: Website Marin Magazine Cinema Ad Other _____

Emergency Contact: _____ Phone: _____

Have you had previous training in the Pilates Method? Yes _____ No _____

If yes, please describe: _____

Pre-existing conditions (please mark all that apply and explain)

✓	Pre-existing Conditions	If yes, please describe onset/location <u>AND DATES</u>
	Abdominal surgery	
	Arthritis	
	Cancer	
	Headaches/Dizziness/Vertigo	
	High/low blood pressure	
	Hip, Knee, Ankle, Foot issues	
	Joint replacement	
	Lower back/disc problems	
	Neurological (MS)	
	Osteoporosis/Osteopenia	
	Pregnancy/Postpartum	
	Sciatica/numbness	
	Scoliosis	
	Shortness of breath	
	Shoulder, Elbow, Hand issues	
	Upper back/neck problems	

Are you currently receiving other types of therapy?

Physical Therapy Acupuncture Chiropractic Therapeutic Massage

Are you currently active in an exercise program? Please describe.

What would you like to accomplish with your Pilates sessions?
