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Client Information Form

Welcome! Our mission is to empower you to be in control of your own health and well being through the Pilates method. To better serve you, we ask that you please take a few minutes to complete this form. Thank you.

Please complete all appropriate fields below. Shaded fields are required.

Name:	
Birth Date:	
Occupation:	
Street Address:	
City, State/Province:	
ZIP/Postal Code, Country:	
Home Phone:	
Cell Phone:	
Email:	

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1. What specific fitness or health goals do you hope to achieve through the Pilates method?

☐ Lose weight
☐ Strengthen muscles
☐ Mind/body connection
☐ Balance
☐ Reduce Stress

Work target area:
Medical reason:
Other:

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2. List all current and any meaningful previous activities.

☐ Pilates
☐ Aerobics/etc.
☐ Skiing
☐ Biking
☐ Hiking
☐ Running
☐ Weightlifting
☐ Swimming
☐ Climbing
☐ Yoga
☐ Walking
☐ Dance

Other:

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3. Describe your present physical condition.

○Poor○Fair○Good○Excellent

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4. Describe your physical history.

Injuries/Surgeries:
Ailments/Illnesses:
Pregnancies:
Other:

Please specify which areas of your body were affected Right (R) or Left (L).

☐	Head	☐	Lower Back
☐	Neck	☐	Ribs
☐	Shoulder	☐	Abdomen
☐	Arm/Hand	☐	Hip/Pelvis
☐	Upper back	☐	Knee
☐	Mid back	☐	Ankle/foot

Other: ☐

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5. How did you find out about The Pilates Center? If applicable please include the name of the person who referred you (friend, doctor, physical therapist, etc.).

☐ Newspaper
☐ Internet
☐ Phone book

Friend: ☐
Doctor: ☐
Other: ☐

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X ______________________________

Signature Certificate

Document name: Client Information Form

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