

STUDENT INFORMATION

NAME _____ DATE _____

ADDRESS _____

MOBILE PHONE _____ HOME/WORK _____

EMAIL ADDRESS _____ JOIN OUR E-NEWS LIST ___ YES ___ NO

AGE/DOB _____ HEIGHT _____ WEIGHT _____

ICE NAME _____ # _____ RELATIONSHIP _____

GOALS _____

HOW DID YOU HEAR ABOUT THIS PILATES PROGRAM? WHO REFERRED YOU?

DO YOU HAVE ANY INJURIES, ACHES OR PAINS, ANY SURGERIES? PLEASE DESCRIBE

ARE THERE ANY OTHER HEALTH CONCERNS? (E.G. ASTHMA, HIGH BLOOD PRESSURE, AUTOIMMUNE DISEASES)

ARE YOU PRESENTLY DOING OTHER KINDS OF THERAPY? (E.G. MASSAGE, CHIROPRACTIC, PHYSIO, ACUPUNCTURE...

ARE YOU/WERE YOU ACTIVE IN ANY SPORTS OR EXERCISE PROGRAMS? PLEASE DESCRIBE

HAVE YOU HAD ANY PAST TRAINING IN THE PILATES METHOD OF MOVEMENT? IF YES, WHERE & WHEN?

WHAT IS YOUR OCCUPATION? WHAT DOES YOUR TYPICAL DAY INVOLVE PHYSICALLY – YOUR DAILY ACTIVITIES?

DO YOU TAKE ANY MEDICATIONS OR SUPPLEMENTS? PLEASE LIST

DO YOU HAVE ANY ALLERGIES? ___ YES ___ NO IF YES, PLEASE NAME:
