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:

_____