CONSCIOUS BODY PILATES - CLIENT INFORMATION FORM

Name:		**Date:** _____/_____/_____
Address:		**Apt. #**
City:	**State:**	**Zip:**
Best Phone #s To Call:	**E-mail:**	
Date of Birth: ___/___/___	**Occupation:**	
Emergency Contact Name:	**Em Ctc. Phone:**	

GOALS AND INTERESTS

Please tell us your "big picture" goals for your health and fitness.

1. _____
2. _____
3. _____

Related to your big picture, what are some specific outcomes you'd like to achieve?
Please check all that apply.

- ☐ Improved posture
- ☐ Increased core strength
- ☐ Increased muscle strength/tone
  Where? _____
- ☐ Stress relief
- ☐ Feel better about my body
- ☐ Increased aerobic fitness
- ☐ Increased flexibility
- ☐ Improved balance
- ☐ General health benefits
- ☐ Gain weight
- ☐ Lose weight
- ☐ Injury rehab
  Where? _____
- ☐ Sport-specific performance gains
- ☐ _____
- ☐ _____

What kinds of activities do you enjoy (or are willing to try)? Please check all that apply.

- ☐ Indoor cycling
- ☐ Walking/running on a treadmill
- ☐ Walking/running outdoors
- ☐ Elliptical machine
- ☐ Weight training/free weights
- ☐ Stretching
- ☐ Rowing
- ☐ _____
- ☐ _____

How did you hear about us? _____

Our mission is to provide the highest quality of Pilates and personal fitness instruction to people of all needs and abilities in a challenging, rewarding and fun environment. ***We succeed when you are so pleased with your results that you tell others about us. So please let us know if you ever feel that we are not meeting your needs.*** *Thank you and we look forward to working with you!*

PLEASE CONTINUE TO NEXT PAGE

HEALTH HISTORY

Please describe your current physical condition, including acute or chronic pain and any movement restrictions: _____

_____

Please check all that apply: *If applicable, please explain below.*

- ☐ back pain
- ☐ joint problems/pain
- ☐ rheumatoid arthritis
- ☐ osteoarthritis arthritis
- ☐ osteopenia
- ☐ osteoporosis
- ☐ chronic fatigue
- ☐ fibromyalgia
- ☐ bone breaks/fractures
- ☐ sprains/tendon or ligament tears
- ☐ surgery
- ☐ cancer

Please add any additional relevant medical history (e.g., prescriptions):_____

_____

Please assess your health by checking all that apply:

History (have you had…)

- ☐ any cardiovascular condition
- ☐ a heart attack
- ☐ heart or vascular surgery
- ☐ heart valve disease
- ☐ congenital heart disease
- ☐ heart murmur
- ☐ pacemaker/implantable cardiac defibrillator
- ☐ heart transplant

Symptoms:

- ☐ chest discomfort with exertion
- ☐ unreasonable breathlessness
- ☐ dizziness, fainting and/or blackouts
- ☐ heart palpitations or a noticeable rhythm disturbance
- ☐ ankle swelling or other edema
- ☐ burning or cramping in the lower legs when walking short distances

Other Health Issues:

- ☐ diabetes
- ☐ asthma/other lung disorder
- ☐ pregnancy
  How many weeks?____
- ☐ postpartum
  How recently?_____
  - ☐ C-Section
- ☐ Vaginal

If you marked ANY of the statements in the section above, consult your healthcare provider BEFORE engaging in exercise. We will require medical clearance from your physician/health care provider before prescribing an exercise program.

Please mark all that apply:

- ☐ You are a man older than 45.
- ☐ You are woman older than 55, *or* you have had a hysterectomy, *or* you are postmenopausal.
- ☐ You smoke, or have quit in the last 6 months.
- ☐ Your blood cholesterol level is unknown or > 200 mg/dL.
- ☐ Your blood pressure is unknown, is greater than 140/90, or you take blood pressure medication.

If you marked any of the statements in the section above, you may wish to consult your healthcare provider BEFORE engaging in exercise. You may benefit from having professionally qualified exercise staff guide your exercise program. If you did not mark any of the boxes above, you should be able to exercise safely without consulting your healthcare provider.