

PILATES STUDIO of Central Ohio

CLIENT PROFILE

Name _____ Phone () _____ Birthdate / / Sex _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Referred by: _____

EMAIL _____

Accident and Injury History—Please tell us about all accidents and injuries including any permanent problems

Chronic Illness: _____

Have you ever had: High Blood Pressure Heart Problems Joint Problems Diabetes
 Surgery Liver Disease Sprains Fractures Asthma Cancer (type _____)

Please explain:

What kind of exercise is currently in your life? _____

What type of movement have you experienced?

Dance Yoga Martial Arts Running Swimming Aerobics Nautilus None

Sports (please list) _____

Other (please specify) _____

Are you pregnant? yes no Have you recently given birth? _____

Medications you are now taking _____

Is there anything else that could affect your work with us? Please describe: _____

Are you currently receiving care through:

Physical Therapy – Therapists name _____ Phone _____

Chiropractic – Dr's Name _____ Phone _____

Massage or other bodywork – Name _____ Phone _____

Physician - Name _____ Phone _____

In the event of an emergency CONTACT: _____ Phone _____