INNER STRENGTH PILATES

New Client Intake Forms

Name:	DOB:
Address:	Occupation:
Email:	Emergency Contact Name:
Phone:	Emergency Contact Phone Number:

Client Health History

QUESTION	YES	NO	QUESTION	YES	NO
Do you Have vertigo?			Do you have Osteopenia/porosis?		
Do you have high blood pressure?			Do you have blurred vision?		
Do you have a history of heart problems?			Do you have diabetes? Type I or II?		
Do you suffer asthma?			Have you had a hernia?		

Injury/Illness? Cancer?
Chronic pain? Condition?
Any Surgery?
Pregnancy?
Medications?

Current Exercise Routine and Goals

Current activities?
What do you want to get out of Pilates?
Comments/Concerns?
How do you hear about Inner Strength Pilates?

This information is true and accurate to the best of my knowledge.

Participant's Signature **Date**