

# CenterPoint Pilates

## Client Intake and Profile

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Have you ever been treated by a physician for:

- |  |   |
|--|---|
| <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Facet Joint Syndrome                     |
| <input type="checkbox"/> Chronic Fatigue Syndrome  | <input type="checkbox"/> Herniated or Bulging Discs               |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Spondylolisthesis                        |
| <input type="checkbox"/> Fibromyalgia              | <input type="checkbox"/> Stenosis                                 |
| <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Total Hip Replacement                    |
| <input type="checkbox"/> Gastric Reflux            | <input type="checkbox"/> Osteopenia/Osteoporosis                  |
| <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Peripheral Neuropathy (numbness/tingles) |
| <input type="checkbox"/> Multiple Sclerosis        | <input type="checkbox"/> Rheumatoid Arthritis                     |
| <input type="checkbox"/> Orthopedic/Joint Problems | <input type="checkbox"/> Adhesive Capsulitis (frozen shoulder)    |
| <input type="checkbox"/> Knee Injuries             | <input type="checkbox"/> Rotator Cuff Impingement                 |
| <input type="checkbox"/> Carpal Tunnel Syndrome    | <input type="checkbox"/> Thoracic Outlet Syndrome                 |
| <input type="checkbox"/> Plantar Fasciitis         |   |

Are you pregnant: yes no Prior Deliveries: \_\_\_\_\_

Prior Surgeries: \_\_\_\_\_

Prior Injuries: \_\_\_\_\_

Occupation: \_\_\_\_\_

Current Medication: \_\_\_\_\_

Current Fitness Program (activity and frequency): \_\_\_\_\_

What are your fitness goals? \_\_\_\_\_

Have you done Pilates before? If so, where, when, how long? \_\_\_\_\_