human movement STUDIO
PILATES FOR YOUR BODY

5501 N. Swan Road, Suite 215
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CLIENT HISTORY

Name: _____ Date of Birth: _____

Please check all that apply (provide explanations, if applicable):

- ☐ Arthritis
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Scoliosis
- ☐ Osteopenia / Osteoporosis
- ☐ Balance Issues
- ☐ Orthopedic Problems: Knee, Hip, Back, other: _____
- ☐ Glaucoma
- ☐ Asthma
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Seizures
- ☐ Migraines
- ☐ Hearing Loss
- ☐ Concussions
- ☐ Tattoos

Explanation:

_____

_____

_____

List any accidents or injuries with dates:

_____

_____

_____

Surgeries with dates:

_____

_____

_____

Do you need a doctor's permission to exercise?

☐ Yes ☐ No

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What types of exercise do you routinely participate in?

_____

_____

_____

What are your health and fitness goals?

_____

_____

_____

List in order of most important to least important any pain or dysfunction you feel is present in your body:

	Frequency of Pain (daily?)
1._____	_____
2._____	_____
3._____	_____

☐ No symptoms or painful issues currently.

Have you seen a general practitioner or specialist for any of these problems?

☐ Yes ☐ No

Was there any treatment or diagnosis given?

☐ Yes ☐ No

Has the condition changed with treatment?

☐ Yes ☐ No