

New Haven Pilates Client Info & Health Questionnaire

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| NAME: | DATE: |
| What is your Occupation? and/or Daily routine? | |
| What does your typical day involve physically? e.g. sitting at a computer, lifting, etc. | |
| Do you have any Spinal injuries? (Disc or vertebrae injuries; Osteoporosis or Osteopenia) | |
| Do you have any other injuries, aches or pains? Ever been involved in an Accident (auto, sports, Fall or Slip) | |
| Are you on any medications? _____ please list: | |
| Are there any medical or health concerns? e.g., asthma, diabetes, high blood pressure, heart disease? | |
| Are you presently doing other kinds of therapy? e.g., massage, chiropractic, acupuncture, etc? | |
| Are you or were you active in any sports, exercise programs, physical activity? Please describe. | |
| Have you had any past training in the Pilates method of movement? If yes; when and where? | |
| What are your goals? What do you want most from this program? | |
| How did you discover New Haven Pilates? | |