Evaluation Form

Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phones: ( ) _____ **Email:** _____

Emergency Contact: _____ **Phone:** _____

Have you ever been diagnosed with any of the following:

Arrhythmias	Yes / No	Hypo or Hyperglycemia	Yes / No
Arthritis	Yes / No	Neck or Cervical Pain	Yes / No
Back pain	Yes / No	Numbness	Yes / No
Diabetes	Yes / No	Osteoporosis or Osteopenia	Yes / No
Disc Problems	Yes / No	Pelvic Floor Dysfunction	Yes / No
Fibromyalgia	Yes / No	Seizure Disorder	Yes / No
Heart Disease	Yes / No	Vertigo	Yes / No
High or Low Blood Pressure	Yes / No	Other _____	Yes / No

Please list any medications you are currently taking:

_____

_____

_____

Please list any surgeries you have had:

_____

_____

_____

Are you pregnant or have you recently had a baby? Yes / No

Do you lose your balance due to dizziness or lose consciousness? Yes / No

Do you feel pain in your chest when you do physical activity? Yes / No

Please elaborate on your fitness goals (check all that apply):

- o Improve strength or balance (circle)
- o Improve flexibility
- o Injury prevention
- o Change current body composition
- o Learn better eating habits
- o Stress management
- o Sport specific improvement: _____
- o Other: _____

Have you ever done Pilates before?
Yes / No

If YES, please describe what type of Pilates (mat, barre, private, group, rehab):

_____

_____

_____

What kind of services are you interested in? (Check all that apply):

- o Group classes
- o Private lessons
- o Duets or trios

How did you hear about us?

- o Facebook
- o Referred from a friend
- o Online
- o Printed Ad
- o Other: _____

Please explain your current fitness regimen (strength training, cardio program, walking, etc):

_____

_____

_____