KAREN CHAPPELL pilates

Today's Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home: _____ Work: _____ Cell: _____

Date of Birth: ____ / ____ / ____ Occupation: _____

Email _____

Referred by: _____

Emergency Contact: _____ Phone: _____

What are your fitness or exercise goals? _____

_____

List current exercise and activities _____

_____

Do you have any prior experience with Pilates? Y or N
If yes, please describe: _____

Do you now have, or previously had, any injuries? Y or N
If yes, please describe: _____
_____

Has a physician ever restricted your physical activity? Y or N
If yes, please describe: _____

Describe your present physical condition:_____

List any health concerns by area, indicating L or R side as applicable. Indicate any significant medical treatments and/or conditions (i.e. pregnancy, surgeries, etc.) Describe below.

___ Head	___ Arm/Hand	___ Lower Back	___ Hip/Pelvis
___ Neck	___ Upper Back	___ Ribs	___ Knee
___ Shoulder	___ Middle Back	___ Abdomen	___ Ankle/Foot

_____