



Date _____

Name _____ Date of Birth _____

Address _____ City _____ Zip _____

Phone (h) _____ (c) _____ (w) _____

Email _____ Occupation _____

Emergency Contact _____ Phone _____

Please circle Yes or No.

1. Has your doctor ever said that you have limiting conditions and that you should only do physical activity recommended by a doctor? Yes/No

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

3. In the past month, have you had chest pain when you were not doing physical activity? Yes/No

4. Do you lose your balance because of dizziness or do you ever lose consciousness? Yes/No

5. Do you have a bone or joint problem that could be made worse by a change in your physical activity? Yes/No

6. Do you have any injuries—past or present? Yes/No
If so, where _____

7. Have you had any surgeries? Yes/No
If so, where _____

8. Is your doctor currently prescribing drugs (for example, water pills) for blood pressure or a heart condition? Yes/No

9. Do you know of any other reason why you should not do physical activity? Yes/No
If so, what _____

10. Please describe your current fitness program _____

11. What are your fitness goals? _____

12. Have you done any Pilates before? Yes/No

13. If so, briefly describe what type of Pilates have you done (mat, private lessons, rehab, group classes)? _____

14. Are you interested in: _____ Privates _____ Duets _____ Group Classes _____ Open Gym

How did you find out about Pilates Body by Valentin?

___ Friend ___ Yellow Pages ___ Medical Referral ___ Another Student ___ Internet

Other _____