

Pilates Fusion Center, L.L.C.
CLIENT INFORMATION

NAME _____

ADDRESS _____

TELEPHONE _____

E-MAIL _____

BIRTHDATE _____

EMERGENCY CONTACT INFORMATION:

NAME _____

TELEPHONE _____

DO YOU NOW, OR HAVE YOU HAD IN THE PAST:

History of heart problems, chest pain, strokeYes or No

Increased blood pressure or blood cholesterol.....Yes or No

History of breathing or lung problemsYes or No

Recent surgery (within last 12 months).....Yes or No

HerniaYes or No

Do you have any muscle or joint disorders.....Yes or No

Do you have any previous injuries that still affect youYes or No

DOES YOUR PHYSICIAN KNOW THAT YOU ARE PARTICIPATING IN AN EXERCISE PROGRAM?.....Yes or No

How much time can you devote to exercise on a weekly basis? _____

Are you currently exercising regularly.....Yes or No

How did you hear about the Pilates Fusion Center?
