

Dr. Habanova's Pilates Method™ at The Pilates Wellness Center Client Information Form

Welcome to Dr. Habanova's Pilates Method™ at the Pilates Wellness Center. In order for our Certified Pilates Instructors and Licensed Massage Therapists to serve you better, please fill this form out to the best of your abilities. Place "N/A" next to the information you feel does not pertain to you. We hope you enjoy Dr. Habanova's Pilates Method.

Name (Last): _____		(First): _____		(Middle): _____		Age: _____	
Home Address: _____			City: _____		State: _____		Zip: _____
Seasonal Address: _____			City: _____		State: _____		Zip: _____
Home Phone: _____		Cell: _____		Work: _____		Fax: _____	
Birth Date: _____		How did you hear about us?: _____			Email: _____		
Emergency Contact: _____			Relationship: _____			Phone: _____	

Please tell us about your Pilates Experience. Professional Equipment: ____ Professional Mat: ____ Gym Pilates: ____ Video: ____

Please tell us what your Pilates Fitness, Pilates Rehabilitation and Sports Specific goals are.

Leaner: _____	Flexibility: _____	Improve Posture: _____	Increase Mind Body Awareness: _____
Longer: _____	Increase Tone: _____	Decrease Pain: _____	Improve Range of Motion: _____
Firmer: _____	Increase Energy: _____	Improve Health: _____	Improve Performance: _____
Stronger: _____	Feel Better: _____	Improve Balance: _____	Other: _____

What do you do for physical activity? _____

How often would you like to do Pilates? _____ Cardio Vascular Training? _____ Sport Specific Training? _____

Are you a Dressage Rider? _____ Hunter/Jumper? _____ Polo Player? _____ Tennis Player? _____ Golfer? _____

How much water do you drink daily? _____ List all supplements and medications: _____

Are you currently experiencing any physical problems? If so, please explain: _____

Are you currently receiving Chiropractic or Medical Care, Massage Therapy, or Physical Therapy? If so, please explain: _____

Please list all previous surgeries, any injuries and fractures, all trauma (even minor) and all car accidents: _____

Have you been diagnosed with any of the following? Please circle all that apply.

Arthritis	Heart Disease	Osteopenia
Back Pain	Heart Attack	Pregnancy
Cancer	Herniated Disc	Scoliosis
Circulatory Disease	High Blood Pressure	Seizure Disorder
Diabetes	Hypoglycemia	Shoulder Impingement
Dizziness	Numbness or Weakness	Stenosis
Fainting Disorder	Osteoporosis	Other: _____

If there is anything you feel we should know and have not asked, please let us know. _____

Do you have a bone or joint problem that could be made worse with physical activity? _____

Do you know of any reason why you should not be doing physical activity? _____

Physician's Name: _____ Address: _____ Phone: _____

I THE UNDERSIGNED, DO HEREBY CERTIFY THAT I HAVE UNDERSTOOD AND COMPLETED THE ABOVE INFORMATION AND KNOW IT TO BE THRUTHFUL AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____