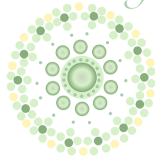


little Sanctuary



Pilates Boutique by Nicole Calvino

## Client Information

### Personal Details - PLEASE PRINT CLEARLY

Date: \_\_\_/\_\_\_/20\_\_\_ Full Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ (Be honest as this is where I will inform you of important information and offers if you are interested)

D:O:B: \_\_\_/\_\_\_/\_\_\_ (year is not necessary, however if you'd like a special Birthday gift from me please complete say and month).

### Emergency Contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

### Medical History:

Do you currently have any injuries? Y/N Details if Y: \_\_\_\_\_

\_\_\_\_\_

Have you ever had any major surgeries of injuries? Y/N Details if Y: \_\_\_\_\_

\_\_\_\_\_

Are you currently taking any medications that may effect your ability to exercise? Y/N Details if Y:

\_\_\_\_\_

\_\_\_\_\_



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Are you pregnant? Y/N If yes, when is your due date? \_\_\_\_\_

Do you or have you ever suffered from any of the following conditions which may effect your ability to exercise? (If yes please provide deatils)

- |  |  |
|--|--|
| <input type="checkbox"/> Heart Diesase/Condition | <input type="checkbox"/> Diabetes                    |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy                    |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Hernia                      |
| <input type="checkbox"/> Fibromyalgia            | <input type="checkbox"/> Multiple Sclerosis          |
| <input type="checkbox"/> Osteoporosis            | <input type="checkbox"/> Scoliosis/Kyphosis          |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Back Injury                 |
| <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Other (please give details) |

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**Fitness Details:**

Have you previously practiced Pilates? Y/N If yes, how long have you been practicing?

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Would you say you were a            Beginner            Intermediate            Advanced practitioner.

Do you participate in any other forms of exercise or sport? Y/N

Details: \_\_\_\_\_

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**Please advise the instructor before each class if any of the above information changes. It is always recommended to consult a doctor before beginning any new form of physical activity.**

**I acknowledge that I have completed this form truthfully & accurately.**

Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / 20 \_\_\_\_