

Cassandra's ABSolute Pilates

Information Request

Name: _____ Sex: M (), F () AGE: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: Home _____ Cell _____ Email _____

Emergency Contact:

Name _____ Phone _____ Relationship _____

Do you have any injuries or conditions that may limit to any degree your ability to participate in physical activities? _____

List any medications you are currently taking: _____

Have you had any of the following? If so, please give descriptions and dates.

Surgeries: _____

Broken bones: _____

Dislocated joints: _____

Torn muscles: _____

Physical therapy: _____

Are you currently engaged in any exercise/sports/physical activities? Please give details.

Do you experience any physical discomfort during your daily activities? Please give details.

Have you had previous experience with Pilates? () Yes, () No

What are your fitness goals? _____

Please Sign: _____

Date: _____

Please Print _____