

SOMATIC PILATES HEALTH QUESTIONNAIRE

PLEASE FILL OUT THIS FORM TO THE BEST OF YOUR ABILITIES AND SIGN THE STATEMENT AT THE BOTTOM OF THE FORM.

Last Name: _____ First Name: _____

Phone Number: _____ Age: _____ Preferred Gender Pronoun: _____

Emergency Name and Contact Number: _____

How did you hear about Somatic Pilates: _____

Previous Experience with Pilates: _____

General Health (Check): _____ Excellent _____ Good _____ Fair _____ Poor

Are You Currently Experiencing Any Health Issues? If So, Please Explain: _____

Medications: _____

Previous Injuries: _____

Previous Surgeries: _____

Are You Currently Receiving Professional Health Care Services (i.e. Chiropractic, Medical, Massage, Rolfing, Physical Therapy, Etc...): _____

Please describe any physical issues below and on the figures to the right:

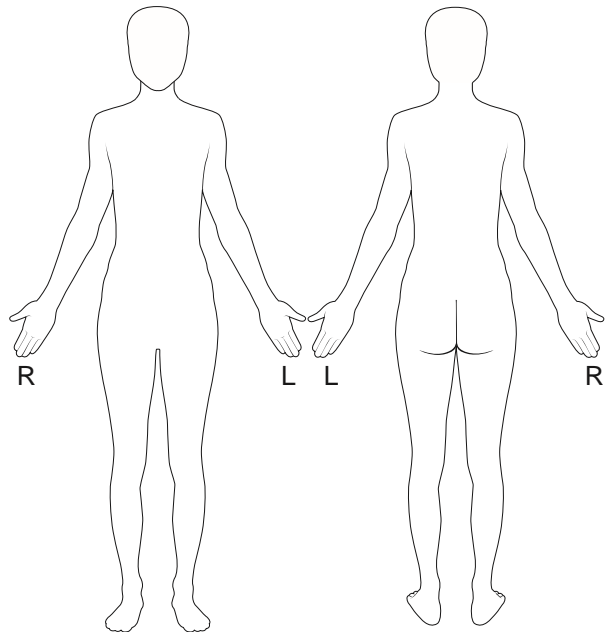
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Please list other forms of exercise or recreational activities that you routinely participate in:

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-
-

What are your goals for participating in this program?

-



FRONT

BACK

Please mark any areas which are causing discomfort.