Pilates Plus Wellness Center
301-952-1111 | 973-498-6955 (fax) | www.pilatespluscenter.com

Client Intake Form

Name:_____ Date of Birth:

Address: _____ Phone:

_____

Married Status: ____M ____D ____S

Occupation:_____ M____ F____

Nearest Relative in case of emergency:_____

Phone Number:_____

Present Health Status: Check each column where symptoms apply and elaborate in space provided below. Use extra sheets of paper if necessary.

General:
___ Allergies
___ Convulsions
___ Dizziness
___ Fainting
___ Fatigue
___ Headaches
___ Nervousness
___ Numbness

Woman:
___ Menopausal
___ Hot Flashes
___ Mood Swings
___ Irregular Cycle
___ Breast Lumps
___ Infertility
___ Vaginal Discharge
___ Lower Back Pain

Skin:
___ Boils
___Acne
___Dryness (lacking oil)
___Dehydrated (lacking water)
___Itching
___Varicose veins
___Inflamed/sensitive

Muscles & Joints:
___Backache/Upper
___Backache/Lower
___Broken Bones
___Mobility Limitations
___Spinal curvature

Cardiovascular:
___High Blood Pressure
___Low Blood Pressure
___Pain in heart area
___Poor Circulation
___Swelling of Ankles/joints

Respiratory:
___Chest Pain
___Difficulty Pain
___Dry Cough
___Spitting Blood
___Congestion

Pilates Plus Wellness Center
301-952-1111 | 973-498-6955 (fax) | www.pilatespluscenter.com

___Sprained Tendons/muscles
___Stiff Neck
___Swollen Joints

___Previous Heart Stroke/murmur

Gastro-intestinal:
___Belching
___Constipation
___Abdominal Pain
___Colitis

Ears, Eyes, Nose, Throat:
___Asthma
___Ear Aches
___Eyes pains, Dry/Wet
___Failing Vision
___Sinus Infection
___Sore Throat
___Sinus Congestion

Men:
___Jock Itch
___Prostate
___Urinary discharge
___Blood in urine
____Impotency
___Infertility

Today's Date:_____Birthdate:_____Height:_____Weight:_____

Indicate all surgeries you have had and give dates: _____
_____

Please list any pharmaceuticals you are now taking:

If you were to choose one or two EMOTIONS which seem predominant in your life, they would be:

_____And_____

Please indicate approximate dates and briefly describe the nature of any traumatic experiences you have had (e.g. divorce, loss of job, change of residence, injury, death in family, etc.)

_____ _____

_____ _____

_____ _____

(Year) (Event)

Do you now undertake or have you undertaken a restricted diet? Please describe and indicate when:

Please describe your program of physical health.

Pilates Plus Wellness Center
301-952-1111 | 973-498-6955 (fax) | www.pilatespluscenter.com

Female Client only: Indicate your experience of the follow as on the first page:

_____ vaginal infection with discharge
_____ yeast infection
_____ urinary tract infection
_____ ovarian cyst
_____ pelvic inflammatory disease

_____ breast lumps
_____ irregular cycles
_____ menstrual cramps
_____ infertility

_____ genital burning
_____ positive PAP
_____ hemorrhoids
_____ anal fissures

Please indicate the number of children you have had: _____

Male Clients only: Indicate your experience of the follow as on the first page:

_____ prostatitis
_____ burning urination
_____ urinary incontinence

_____ nocturnal emission
_____ pre-mature ejaculation
_____ impotence

PLEASE PROVIDE ANY ADDITIONAL INFORMATION ABOUT YOU AND YOUR CONDITION THAT MIGHT NOT HAVE BEEN COVERED BY THE ABOVE QUESTIONS ON THE FACK OF THIS FORM.