



Intake

Name _____ Date _____ / _____ / _____

Address _____ Apt # _____

City _____ State _____ Zip _____
(_____) - _____ (_____) - _____

Home Phone _____ Work Phone _____
(_____) - _____

Cell Phone _____ Email _____

Occupation _____ Employer _____

Referred by _____

Emergency Contact _____

(_____) - _____
Phone _____ Relationship _____

/ / _____
Date of Birth _____ Height _____ Weight _____

Dominate Hand: Right Left

PLEASE CHECK ALL THAT APPLY:

- SPINAL PROBLEMS
- SPEND MUCH OF MY DAY SITTING _____ HOURS/DAY
- PREGNANT
- WEAR CONTACTS/GLASSES
- DIABETES
- BALANCE ISSUES
- HEART PROBLEMS
- EXPERIENCE VERTIGO
- HIGH BLOOD PRESSURE
- DRINK ALCOHOL _____ DRINKS/WEEK
- SMOKE
- DRINK CAFFEINE _____ CUPS/DAY

PLEASE EXPLAIN ALL CHECKED BOXES:

PLEASE RATE YOUR PAIN ON THE SCALE BELOW (0 = no pain, 5 = severe pain):

0 **1** **2** **3** **4** **5**

ARE YOU TAKING MEDICATION? **YES** **NO**

IF YES, LIST AND EXPLAIN:

PLEASE LIST AND DATE ANY SURGERIES, FRACTURES OR PREGNANCIES (Include any C-sections or complications if applicable)

HAVE YOU HAD ANY TRAUMAS (such as a fall) OR ACCIDENTS (car, work related etc.)? IF SO, WHAT REHABILITATION DID YOU RECEIVE?

ARE THERE ANY OTHER MEDICAL CONDITIONS OR PHYSICAL INJURIES I SHOULD BE AWARE OF?

WHAT IS YOUR MOST COMMON SLEEP POSITION? (e.g. back, stomach, or right/left side)?

WHAT PHYSICAL ACTIVITIES OR HOBBIES DO YOU LIKE TO DO CURRENTLY?

BRIEFLY DESCRIBE YOUR DAILY ROUTINE. PLEASE INCLUDE APPROXIMATE TIMES SPENT DRIVING, SITTING AND STANDING.

ARE YOU PRESENTLY DOING OTHER KINDS OF THERAPY (massage, chiropractic, acupuncture, physical therapy)? IF YES, EXPLAIN

HAVE YOU HAD ANY PAST PILATES AND/OR MOVEMENT TRAINING? IF YES, WHERE AND FOR HOW LONG?

WHAT IS THE REASON FOR YOUR VISIT? WHAT ARE YOUR GOALS? WHAT DO YOU HOPE TO GAIN FROM THIS PROGRAM? (please be specific)

I understand that the practitioner does not diagnose illness, disease or any physical or mental disorder. It is clear to me that this is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician before starting any physical program for any ailment that I might have. I have stated all my known medical conditions and take it upon myself to keep the practitioner updated on my physical health. This is a hands-on studio. Please inform instructor if this is a problem for you. **PLEASE NOTE: if you are unable to keep your appointment you are required to notify Balanced Place at least 24 hours in advance or agree to pay in full for the missed appointment.**

Signature _____ *Date* _____ / _____ / _____