Transformation
Pilates Studio

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# EVALUATION FORM

NAME:_____ DATE:_____

PHONE: (H)_____(C)_____(W)_____

DOB:_____ EMAIL:_____

ADDRESS:_____

CITY:_____ZIP:_____

EMERGENCY CONTACT:_____PHONE:_____

***PLEASE CIRCLE YES OR NO.***

1. Have you done any form of Pilates before? Yes/No

2. If so. briefly describe what type of Pilates you have done (mat, private lessons, rehab, group lessons):_____

3. Are you pregnant or have recently had a baby? Yes/No Please let us know if there is anything additional we should know about your pregnancy:
_____

4. Have you had any surgeries? Yes/No If you answered yes, please describe what type and when:

_____

_____

5. Are you taking any medication? Yes/No If you answered yes, please list:

_____

6. Are you currently involved in a strength training and/or cardio program? Yes/No
If so what form of exercise and how often:_____

7. Has your physician ever said that you have limiting conditions and/or that you should only do physical activity recommended by a physician? Yes/No

8. Do you feel any pain in your chest when you do physical activity? Yes/No

9. In the past month, have you had chest pain when you were not doing physical activity? Yes/No

10. Do you lose your balance because of dizziness or do you ever lose consciousness? Yes/No

11. Do you have a bone or joint problems? Yes/No
If so please describe:_____

12. Do you have any injuries past or present? Yes/No
If so please describe._____

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13. Please describe your current fitness programs_____

14. What are your fitness goals?_____

15. Are you interested in:____Privates ____Duets_____Group Classes____Other

16. How did you find out about Transformation Pilates Studio?

___Friend___Yellow Pages____Another Student____Internet____Other_____