



PILATES & GYROTONIC® INTAKE FORM

Contact information:

Name: _____ Member number: _____

Email: _____ Phone number: _____

PHYSICAL READINESS

	YES	NO
Has a doctor ever told you that you have a heart condition and that you should only perform physical activity recommended by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have chest pain when performing physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
Do you lose your balance because of dizziness or do you ever lose consciousness?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a bone or joint problem (i.e. shoulder, knee or back) that could be made worse by a change in physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
Is your doctor currently prescribing drugs for a blood pressure or heart condition?	<input type="checkbox"/>	<input type="checkbox"/>
Do you know any reason why you should not perform physical activity?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to any of the above questions, we require a physician's referral before beginning an exercise program. Referrals may be emailed to EBC's Director of Pilates and GYROTONIC® Lisa Reynolds at lreynolds@eastbankclub.com or faxed to (312) 527-5666, attn.: Lisa Reynolds.

MEDICAL HISTORY

Please indicate whether you have had any of the following medical problems:

- Asthma Seizures/Epilepsy Cancer Osteoporosis
 Stroke Heart Attack Arthritis Lung Disease
 Diabetes Heart Disease High Blood Pressure Other _____

INJURY HISTORY

Have you had an injury or condition in any of the following areas?

AREA	INJURY OR CONDITION	TREATMENT	CURRENT PAIN LEVEL
Head			
Neck			
Shoulder			
Spine			
Arm/Elbow			
Wrist/Hand			
Pelvis/Hip			
Knee			
Ankle			
Foot			
Abdominals			
Nervous System			

If you are experiencing pain or dysfunction in any of the areas listed above, we recommend that you schedule a complimentary screening with AthletiCo Physical Therapy before your next scheduled appointment.

LIFESTYLE QUESTIONS

What is your occupation? _____

What does your current fitness routine entail? _____

What sparked your interest in Pilates and/or GYROTONIC® training? _____

Do you have any prior experience with Pilates and/or GYROTONIC® training? Yes No

What fitness goals do you hope to achieve through Pilates and/or GYROTONIC® training?

SIGNATURE _____ DATE _____