



Harmony Pilates & Yoga Studio
219 N. Salem St., Suite 103
Apex, NC 27502
919-389-2747
www.harmoniypilatesstudio.com

Office Use
New:
Update:

Client Information

First Name: _____ M: _____ Last Name: _____
Street Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____

Home Phone: () _____ - _____ Cell Phone: () _____ - _____

E-mail: _____
(newsletters & info updates will be distributed via e-mail. Note: We respect your privacy, your email and personal information will never be distributed or sold to other parties)

Birth date: _____ Age: _____ Sex: M / F

Please let us know how you heard about us? Who referred you?

Emergency Contact

Name: _____

Home phone: () _____ - _____ Cell Phone: () _____ - _____ Relationship to you: _____

Health & Fitness Information

To ensure that your exercise program is safe and designed to meet your specific needs, please respond to the following:

Do you exercise regularly? (2-3 times per week) Yes No

If yes, please list the current types of activities you are doing and how often:

Please rate your general level of fitness in the following areas:

Cardiovascular Conditioning-	<input type="radio"/> Low	<input type="radio"/> Moderate	<input type="radio"/> High
Muscular Strength-	<input type="radio"/> Weak	<input type="radio"/> Moderate	<input type="radio"/> Strong
Flexibility-	<input type="radio"/> Stiff	<input type="radio"/> Flexible	<input type="radio"/> Very flexible

Rate your level of experience with *Pilates* by marking with a **P**, and *Yoga* by marking with a **Y**

<input type="checkbox"/> <input type="checkbox"/> Matwork	<input type="checkbox"/> <input type="checkbox"/> Equipment		
<input type="checkbox"/> <input type="checkbox"/> No Experience	<input type="checkbox"/> <input type="checkbox"/> Beginner	<input type="checkbox"/> <input type="checkbox"/> Intermediate	<input type="checkbox"/> <input type="checkbox"/> Advanced

Other movement based types of training you've received past or current:

Health History

It is strongly recommended that you receive medical clearance from your private physician prior to starting this or any exercise training program. Our programs can be designed for persons with medical disorders; however, those persons should have a direct physician referral.

Physician: _____ Office Phone: () _____ - _____

To help keep you safe while designing your exercise program, it is important for us to know more about you. Please help us by completing the information below.

Describe any pre-existing conditions or past injuries that might affect your participation.

Neck _____

Shoulders (Left/Right/Both) _____

Elbow/Wrist/Hands (Left/Right/Both) _____

Back (Upper/Lower/Mid) _____

Legs/Hips/Knees/Ankles (Right/Left/Both) _____

Feet (Right/Left/Both) _____

Please circle any that apply to you:

I have or have had the following condition/s:

High Blood Pressure	Heart Problems	Post-Partum	Neurological
Diabetes	Joint Problems	Seizures	Respiratory
Liver Disease	Fractures	Cancer	Hernia
Pregnant	Smoker	Asthma	Scoliosis
Shortness of Breath	Recent Surgery	Chronic Illness	Balance
Back Problems	Arthritis	Allergies	Other

If you circled any of the above, please explain: _____

Osteoporosis

Please check the following that apply:

_____ tested for Osteoporosis _____ diagnosed with Osteopenia _____ diagnosed with Osteoporosis

If so, when were you tested and what, if any, treatment are you currently under? _____

Please give a brief description of what you are looking for from this program. List 3 goals.

1. _____ 2. _____ 3. _____

HPS appreciates you taking time to thoroughly fill out your personal profile intake form so that we can design a personalized program for your individualized needs.