PILATES PRO INC.
REHABILITATION & CONDITIONING CENTRE

CLIENT INTAKE FORM

Name:		Date:
Address:		
City:	Province:	Postal Code:
Home Phone:	Cell Phone:	Work Phone:
Email:	Marital Status:	
Name Of Family Physician:	Emergency Contact & Phone:	
Date of Birth:	Occupation:	Hobbies:
Who May We Thank For Referring You?		
What Specific Fitness Goals Do You Hope To Achieve?		
Describe Your Present Physical Condition		

History of Present Condition

Describe your major complaint(s):	
How did this happen?	When did this happen?
Has this ever happened before? ☐Yes ☐No	How would you rate your pain severity? /10
How would you describe the symptoms: ☐sharp ☐shooting ☐stabbing ☐weakness ☐dull ☐stiffness other: ☐numb ☐tingling ☐spasm ☐burning ☐achy ☐throbbing	
What makes your symptoms better:	What makes your symptoms worse:
Does the pain radiate/ travel anywhere? ☐Yes ☐No Where?	How often do you experience these symptoms? ☐Intermittently ☐Frequently ☐Constantly
Have you received any form of treatment for your condition? ☐ Yes ☐ No If Yes, what form?	Have you obtained X-Rays, MRI, EMG, CT scans or Lab work? ☐ Yes ☐ No If Yes Which?

Past Health History

		Yes	No	If Yes Please Explain……
Have You….	Been hospitalized in the last 5 years?	☐	☐	
	Had any surgeries	☐	☐	
	Suffered any major physical trauma?	☐	☐	
	Suffered any broken bones ?	☐	☐	
	Have you given birth?	☐	☐	

For each of the conditions listed below, place a check if you are, or have in the past, experienced any of the following:

☐	Headaches	☐	Heart Attack	☐	Excessive Thirst
☐	Neck Pain	☐	Chest Pains	☐	Frequent Urination
☐	Upper Back Pain	☐	Stroke	☐	Chronic Sinusitis
☐	Mid Back Pain	☐	Angina	☐	Smoking/ Tobacco Products
☐	Lower Back Pain	☐	Kidney Stones	☐	Drug / Alcohol Dependence
☐	Sciatica	☐	Kidney Disorders	☐	Allergies
☐	Shoulder Pain	☐	Bladder Infection	☐	Depression
☐	Elbow or Upper Arm Pain	☐	Painful Urination	☐	Systemic Lupus
☐	Wrist Pain	☐	Loss of Bowel or Bladder Control	☐	Epilepsy
☐	Hand Pain	☐	Prostate Problems	☐	Dermatitis/Eczema/Rash
☐	Ankle/Foot Pain	☐	Abnormal Weight Loss or Gain	☐	HIV / AIDS
☐	Jaw Pain	☐	Diminished Appetite		Women Only
☐	Joint Swelling or Stiffness	☐	Abdominal Pain	☐	Birth Control Pills
☐	Arthritis	☐	Ulcer	☐	Pregnancy
☐	Rheumatoid Arthritis	☐	Hepatitis	☐	Hormonal Replacement
☐	General Fatigue	☐	Liver or Gall Bladder Disorder		Other Health Issues
☐	Fibromyalgia	☐	Cancer Type:	☐	
☐	Visual Disturbances	☐	Tumor	☐	
☐	Dizziness	☐	Osteoporosis	☐	
☐	High Blood Pressure	☐	Asthma	☐	
☐	Heart Arrythmias	☐	Diabetes	☐	
☐	Pace Maker	☐	Aneurysm	☐	

Family History: If any blood relative has any of the following conditions, please check and indicate which relative

☐ Anemia	☐ Diabetes	☐ High Blood Pressure
☐ Atherosclerosis	☐ Disc Disorder	☐ High Cholesterol
☐ Arthritis	☐ Emphysema	☐ Multiple Sclerosis
☐ Asthma	☐ Epilepsy	☐ Osteoporosis
☐ Back Ache	☐ Glaucoma	☐ Pinched Nerve
☐ Bleed Easy	☐ Headaches	☐ Stroke
☐ Cancer	☐ Heart Trouble	☐ Thyroid Disease

Medications: Please list any medication you are currently taking and why

Type	Purpose

Please Indicate any other information that may be relevant to your condition:

Investigations: