



# Functional Pilates Intake Form

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Physical Therapist: \_\_\_\_\_

Diagnosis/Reason for PT:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any prior experience with Pilates?  
\_\_\_\_\_  
\_\_\_\_\_

Please briefly tell us about your goals for your Functional Pilates Programming:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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