

# Integrated Motion Studio

## Alexander Technique Student Information Sheet

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Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: c) \_\_\_\_\_ h) \_\_\_\_\_

Zip code: \_\_\_\_\_ Occupation: \_\_\_\_\_

Interests / regular activities: \_\_\_\_\_

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Prior Experience with Alexander Technique or other modalities: \_\_\_\_\_

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Relevant Medical History (e.g. chronic pain/injuries/surgeries/conditions):

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What days and times are you available for lessons?

Times	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7-10am							
10am-12pm							
12-2pm							
3-5pm							
5-7pm							
7-9pm							

Other Relevant Info: \_\_\_\_\_

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How did you hear about the Alexander Technique? \_\_\_\_\_

How did you hear about Molly/Integrated Motion Studio? \_\_\_\_\_

*(Please bring to your first lesson or email to [at@integratedmotionstudio.com](mailto:at@integratedmotionstudio.com))*