The Pilates Place
where how you move matters

Health Screening

Please fill out this form to the best of your abilities and sign the statement at the bottom of the form. If you have any questions, please feel free to ask.

Last Name _____ First Name_____ Occupation _____
Sex _____ Age _____Marital Status _____
Hobbies/Recreational Activities and Frequency _____
_____
Previous Experience with Pilates or Yoga? _____
General Health (Check) _____ Excellent _____ Good _____ Fair_____Poor
Do you smoke? _____If so, how many cigarettes per day?_____ How old were you when you started?_____
If you have quit smoking, when did you quit?_____
How many alcoholic beverages do you usually drink per week?_____
Personal Fitness Goals_____
_____
Are you currently experiencing any physical problems? If so, please explain_____
_____
Medications_____
Previous Injuries _____
Previous Surgeries_____
Are you currently receiving professional healthcare services (i.e. Chiropractic, Medical, Massage Therapy, Physical Therapy, etc.) _____
_____

Are you currently or have you previously been diagnosed with any of the following (please check all that apply:)

- ❑Arthritis
- ❑Back/Neck Pain
- ❑Bowel/Bladder Changes
- ❑Cancer
- ❑Circulatory Disease
- ❑Diabetes
- ❑Osteoporosis
- ❑Heart Disease
- ❑Heart Attack
- ❑Herniated Disc
- ❑High/Low Blood Pressure
- ❑Hypoglycemia
- ❑Hyperglycemia
- ❑ Numbness or Weakness
- ❑Osteopenia
- ❑Pregnancy (currently)
- ❑Seizure Disorder
- ❑Shoulder Impingement
- ❑Stenosis
- ❑Thyroid Disorder
- ❑Dizziness or Fainting
- ❑Chest Pain

Other _____

Is there anything else that you feel we should know about or have not asked? _____
If so, please explain. Use back if necessary. _____

I, the undersigned, do hereby certify that I have completed the above information to the best of my knowledge.

Signature _____ Date _____