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 ____

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