Health History for Pilates at Joyful Motion Pilates

Name (Last/First):_____
Birthdate:_____ Today's date_____
Address:_____
City:_____ State:_____ Zip:_____
Email:_____ Phone:_____

In order to design a safe and effective program, it is important that you complete the following Health History form. It is crucial that you answer all the questions honestly and the best of your ability. **Please be advised that all information is kept confidential.**

A. Check the appropriate response.	Yes	No
1. Has your doctor ever told you that you have heart problems?	____	____
2. Has your doctor ever told you that you have high blood pressure?	____	____
3. Have you ever had a stroke or heart attack?	____	____
4. Have you ever had pain in your chest?	____	____
5. Do you ever feel faint or have dizzy spells?	____	____
6. Have you had surgery in the last six months?	____	____

B. Check the appropriate conditions.

Diabetes Epilepsy Blood pressure Asthma Arthritis High Cholesterol
Heart Pregnancy Osteopenia Osteoporosis

C. Have you injured or do you have pain in the following areas?

Neck Upper Back Shoulders Elbows Lower Back
Hips Wrists Knees

Please explain:_____

D. Are you currently taking any medications? Yes No If you checked "yes", please list medications and for what conditions.

_____

E. Are you currently undergoing treatment from any of the following? Physiotherapist
Chiropractor Massage Therapist

F. What is your current exercise level? None 2-3 times a week 4-5 times per week
What type of exercise:_____

G. What are your exercise goals? Posture, strength, balance, weight loss other?_____

Are there any other reasons (health or personal) that may prevent or limit you from exercising?

_____

_____