Background and Applicable Health History

Date_____ Date of Birth____/_____/_____

First Name:	Last Name:	
Address:		
City:	State:	Zip Code:
Home Telephone:	Work/cell phone:	
Email Address:		
Emergency Contact/phone#:		Relationship:

How did you hear about our studio? Check all that apply.

- ☐ Another Client:_____
- ☐ Friend:_____
- ☐ Radio
- ☐ Stott Website
- ☐ Google Search
- ☐ Other: _____

Please answer the following questions. All information is confidential and will only be used to help your instructor to create a personalized program for you.

Have you had any past training in the Pilates method? **Yes/No.** If yes, for how long and where?

_____

Do you have any injuries or conditions that may influence your ability to exercise? **Yes/No.** If yes, please describe.

_____

_____

Are you taking any medications? **Yes/No.** If yes, please list medication name(s) and side effects. _____

_____

_____

_____

Do you currently have (or do you have a history of) any of the following conditions?

Yes	No	History of or current condition	Describe onset/duration/severity
		Lower back problems	
		Upper back problems	
		Neck problems	
		Disc problems (what levels)	
		Scoliosis	
		Sciatica	
		Numbness or tingling	
		Headaches	
		Dizziness/Vertigo	
		Hip, knee, ankle, foot issues	
		Shoulder, elbow, hand issues	
		Recurrent shoulder dislocation	
		Tendon/ligament/muscle sprains/strains	
		Difference in leg length	
		Joint replacement	
		Arthritis (what type?)	
		Osteoporosis	
		High/low blood pressure	
		Neurological conditions (MS, Parkinson's)	
		Car accident resulting in injury	
		Are you pregnant?	
		Abdominal surgery (hysterectomy) or Hernias	
		Diabetes	
		Asthma/respiratory problems	
		Heart problems	
		High cholesterol	
		Chest pain	
		Prior surgeries/Recent hospitalizations	
		Do you smoke? If yes, how much?	

Have you experienced any major life changes/stressors in the past year? If yes, please explain:

_____

_____

How would you rate your level of stress on a daily basis?

☐ Low ☐ Moderate ☐ High

How many hours do you regularly sleep at night?_____

Are you currently undergoing treatment from any of the following?

☐ Physical/Occupational Therapist ☐ Chiropractor

☐ Other:_____ If so, why?_____

What is your occupation?_____

What does your typical day involve physically? (sitting, lifting, computer, etc.)

_____

_____

On a scale of 1-10, how would you rate your nutrition (1=very poor 10= excellent)? _____

Are you currently following any type of special diet? If yes, explain:_____

_____

Have you been exercising consistently for the past 3 months? **Yes / No**

What is your current exercise level?

☐ None ☐ 2-3 times per week ☐ 4-5 times per week

If yes, what type?_____

What are your goals with Pilates?

☐ Weight loss ☐ Weight gain ☐ Stress reduction

☐ Increase flexibility ☐ Cardiovascular conditioning ☐ Posture

☐ Injury rehabilitation ☐ Increase strength ☐ Other:_____

What other exercises/activities do you participate in? How often do you do them? _____

_____

It is highly recommended that you seek medical approval before participating in any exercise program.