PILATES
For Health

Health Questionnaire

Name: (Please print) .....

DOB: .. .. / ..... / .....

1. Have you ever had an episode of back pain?

- ◯ No
- ◯ Yes

If yes, please give more details: .....

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2. Have you recently had any injuries or surgery?

- ◯ No
- ◯ Yes

If yes, please give more details and date / year: .....

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3. Are you currently experiencing any of the following conditions? If yes, please provide further details

Anaemia ◯ No ◯ Yes .....

Back Pain ◯ No ◯ Yes .....

Bladder or Bowel Disturbance i.e. Loss Of Sensation ◯ No ◯ Yes .....

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Dizzyness ◯ No ◯ Yes .....

Headaches ◯ No ◯ Yes .....

Heart problems ◯ No ◯ Yes .....

High or low blood pressure ◯ No ◯ Yes .....

Joint Pain ◯ No ◯ Yes .....

Menopause ◯ No ◯ Yes . . . . . .

Shortness of breath ◯ No ◯ Yes . . . . . .

Unexplained Weighloss ◯ No ◯ Yes . . . . . .

4. Have you been diagnosed with or had treatment for: Please tick all applicable

- ☐ Asthma
- ☐ Bronchitis / COPD
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fibromyalgia / Chronic Fatigue
- ☐ Joint Hypermobility
- ☐ Joint Replacement
- ☐ Multiple Sclerosis (MS)
- ☐ Osteoarthritis
- ☐ Osteoporosis / Osteopenia
- ☐ Parkinsons Disease
- ☐ Stroke
- ☐ Rheumatoid Arthritis

5. Are you pregnant?

- ◯ No
- ◯ Yes

If yes, how many weeks are you: . . . . . .

When is your due date? . . . . . / . . . . . / . . . . . .