Client Health Questionnaire

Personal Information

Name _____ **Date** _____

How did you hear about us? _____

Address _____

City _____ **State** _____ **Zip** _____

Email _____ **Cell Phone** _____

Home Phone _____ **Work Phone** _____

Age _____ **Date of Birth** _____ **Height** _____ **Weight** _____

Emergency Contact

Emergency Contact _____ **Relationship** _____

Cell Phone _____ **Home/Work Phone** _____

Movement Information

Are you currently involved in any methods of body movement? (Examples: Dance, golf, aerobics, treadmills, walking, etc.) Circle one. Yes No Not Sure

Please provide a brief explanation of your current methods of movement. Include type(s) of activity, duration and frequency: _____

1339-C Oliver Road, Fairfield, CA 94534

_____

_____

What kind of movement feels good to your body? (Examples: Stretching, running, strength training, etc.)

_____

What is your biggest movement concern at this time? (Examples: Range of motion; balance, posture, pain, etc.)

_____

What specific results do you want/expect from your Pilates-based movement practice? _____

_____

Please indicate if you have had any joint injuries or previous surgeries that may limit or affect your ability to exercise. (Check all that apply.)

- ❑ Neck
- ❑ Shoulder(s)
- ❑ Upper Back
- ❑ Lower Back
- ❑ Hip(s)
- ❑ Knee(s)
- ❑ Ankle(s)
- ❑ Hand/ Wrist(s)
- ❑ Foot
- ❑ Elbow
- ❑ Other: _____

Please provide a brief explanation for any of the above that have been checked: _____

_____

Health History

Physician _____ **Phone** _____

Date of Last Physical Exam _____ **Reason** _____

Please list any medication(s) and the reason(s) for taking: _____

_____

_____

_____

Please indicate if you have any of the following conditions. (Check all that apply.)

- ❑ Asthma
- ❑ Arthritis
- ❑ Back Pain
- ❑ Cancer
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fibromyalgia / CFS
- ❑ Heart Disease
- ❑ Hernia
- ❑ Hypertension (high BP)
- ❑ Hypotension (low BP)
- ❑ High Cholesterol
- ❑ Osteoporosis / Osteopenia
- ❑ Other Joint Pain
- ❑ Stroke
- ❑ Other: _____

Please provide a brief explanation for any of the above that have been checked: _____

_____

Have you had any recent or relevant surgeries? If so, please describe: _____

_____

Do you currently smoke or vape (circle one)? Yes No

Are you pregnant (circle one)? Yes No

Do you have your doctor's clearance to perform physical activity (circle one)? Yes No Not Sure

Do you know of any other reason why you should not engage in physical activity? Yes No Not Sure

If you have answered "Yes" to one or more of the above questions, consult your physician before engaging in physical activity. After a medical evaluation, seek advice from your physician on what type of activity is suitable for your current condition.

To the best of my knowledge, I certify that the above information is true.

Signature _____ **Date**_____

 1339-C Oliver Road, Fairfield, CA 94534