PILATES PAR Q

Today's Date: **Date of Birth:**

Name _____ **Age**_____ **Female / Male**

Address _____ **Zip**_____

Home Phone _____ **Cell phone**_____

Physician _____ **Email**_____

Emergency Contact_____ **Phone**_____

Rate your current health: Excellent Good Average Poor

Are you on any medication? Yes or No _____
What is it for? _____

Do you exercise regularly? Yes No _____
How often? _____

Do you now or have you had in the past:		Yes	No
History of heart problems, chest pains or stroke	1.	_____	_____
Increased blood pressure	2.	_____	_____
Any chronic illness or condition	3.	_____	_____
Difficulty with physical exercise	4.	_____	_____
Advice from physician not to exercise	5.	_____	_____
Recent surgery (last 12 months)	6.	_____	_____
Pregnancy (now or within last 3 months)	7.	_____	_____
History of breathing or lung problems	8.	_____	_____
Muscle, joint, or back disorder	9.	_____	_____
Diabetes or Thyroid condition	10.	_____	_____
Cigarette smoking habit	11.	_____	_____
Increased blood cholesterol	12.	_____	_____
History of heart problems in immediate family	13.	_____	_____
Hernia, or any condition that may be aggravated by resistance	14.	_____	_____

Please explain any yes answers:

_____

Have you had an injury, surgery, or other problem with any of the following:

( ) Ankle ( ) Back ( ) Hip ( )Neck ( )Knee ( )Wrist ( ) Elbow ( ) Shoulder

***All information will be kept private and confidential