

The Scoop On Pilates Medical History

Today's Date:

Name			
Address:			
Phone:			
Date of Birth:	Sex:		
E-mail:			
Please Circle any of the following that apply:			
High Blood Pressure	Heart Problems	Cancer	
Diabetes	Joint Problems	Pregnancy	
Liver Disease	Fractures	Chronic Illness	
Night Pain	Seizures	Asthma	
Shortness of Breath	Recent Surgery	Smoker	
Osteoporosis	Back Problems	Scoliosis	
Please Circle the types of movements you have experienced:			
Dance	Yoga	Martial Arts	Running
Team Sports	Aerobics	Swimming	
Other:			
Are you taking any medications or receiving any medical treatment that might make it unsafe for you to participate in this fitness program?			
How did you hear about this program?			
Please circle the level you like to work out at: light, light to moderate, moderate to hard or hard?			
Anything you would like to share with instructor?			