Client Health History

Name: _____ Age: _____ Date of Birth: _____

Phone #: _____ Email: _____

Have you ever participated in Pilates? yes no If so, please explain:

_____

How would you describe your current fitness level (circle one)? Excellent Fair Poor

How would you describe the physical demands of your job? Light Moderate Heavy

List your current fitness/recreational activities:

_____

Tell us about your fitness goals:

_____

Have you ever been restricted from physical activity by your doctor? yes no If so, please explain:

_____

Are you currently or have you ever experienced the following (please mark each that apply):

- ○ Heart Trouble, Chest Pain, or Palpitations
- ○ Chronic Coughing or Wheezing
- ○ Back Pain
- ○ Muscle pain
- ○ Difficulty Walking, Running, Sitting, Lying
- ○ Dizziness
- ○ Paralysis
- ○ Are you Pregnant? When are you due? _____
- ○ Other Condition
- ○ Shortness of Breath
- ○ Joint Pain and/or
- ○ Neck Pain
- ○ Cold or Tingling
- ○ Frequent Headaches
- ○ Seizures or
- ○ Memory Loss or
- ○ Psychiatric Disorders

If you checked any of the above, please explain:

_____

_____

_____

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