

Personal Details

Name _____
 Address _____

 Postcode _____
 Home Tel _____
 Work/Mobile Tel _____
 Email _____

Sex Male: ☐ Female: ☐

Date of Birth _____

Occupation _____

Sports, Hobbies _____

Emergency Contact Details

Name _____

Home Tel _____

Work/Mobile Tel _____

All information provided will be treated in the strictest of confidence.

PART 1: Your current medical history

YES NO Have you done pilates before?

☐ ☐

YES NO Diabetes? If yes, please circle whether IDDM or NIDDM (Diet or medication controlled?) Are your glucose levels normalised?

☐ ☐

YES NO High or low blood pressure (BP)? If high, is your BP stabilised on medication or on Beta-blockers?

☐ ☐

YES NO Do you have medical clearance to exercise?

☐ ☐

YES NO Cardiac/heart problems? If yes, have you had an exercise stress test?

☐ ☐

YES NO If injured have you been cleared to exercise by your doctor?

☐ ☐

YES NO Epilepsy? If yes, have your seizures been stabilised on medication?

☐ ☐

YES NO Asthma or other breathing problems? If yes do you require regular medication during exercise?

☐ ☐

YES NO Have you been diagnosed with osteopenia/osteoporosis?

☐ ☐

YES NO Do you suffer from digestive complaints (ulcers, reflux, colitis etc?)

☐ ☐

YES NO Have you noticed any bowel or bladder dysfunction? If yes, please provide details:

☐ ☐

YES NO Have you noticed any recent unexplained weight loss?

☐ ☐

YES NO Have you been diagnosed with any form of cancer? If yes, where?

☐ ☐

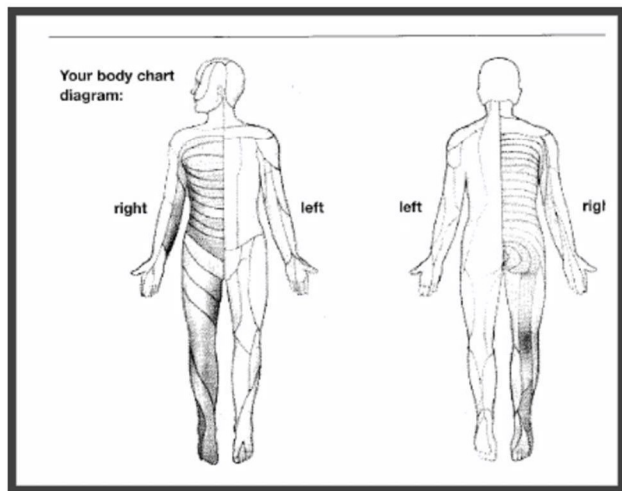
YES NO Do you suffer from any neurological conditions or disease?

☐ ☐

YES NO Is there any other condition or disability not covered above that your therapist should be aware of in treating you as a Pilates client? Activities include stretching, bending, muscle strengthening and breathing exercises:

☐ ☐

YES NO Is there any other condition or disability not covered above that your therapist should be aware of in treating you as a Pilates client? Activities include stretching, bending, muscle strengthening and breathing exercises:



Notes:

PART 2: Your symptom specific history

YES NO Do you experience pain or discomfort?

☐ ☐

If NO continue to PART 3. If YES:

where is the discomfort? (e.g. outside of my left knee or under my right shoulder):

Present since? (if the result of an injury please summarize, e.g. motorcycle or skiing accident):

What is your typical or average pain?

0 (no pain) - 10 (worst possible pain)

What is your pain right now?

0 (no pain) - 10 (worst possible pain)

YES NO Are you taking any pain relieving medication now?

☐ ☐

Is it: Improving ☐ Unchanging ☐ Worsening ☐

Is it worse: Morning ☐ Afternoon ☐ At Night ☐

What makes your discomfort better?
(relieving factors):

What makes your discomfort worse?
(aggravating factors):

Please summaries any previous treatments and outcomes:

Please provide the name(s), occupation and telephone number of any relevant person currently treating you?:

YES NO Do you give me permission to contact them?

☐ ☐

PART 3: Your pregnancy history (where applicable)

YES NO Are you or could you be pregnant now?

☐ ☐

If yes, when is your due date?

Have you had any pregnancies? If so, how many? Please list delivery years:

Delivery type: Natural ☐ Caesarean ☐ Assisted ☐

Additional pregnancy information:

PART 4 : Your past medical history

YES NO Have you been involved in a major accident? (Including motor vehicle accidents?)

☐ ☐

If yes, please specify:

YES NO Have you had any surgery?

☐ ☐

If yes, please specify:

YES NO Have you had any bone or stress fracture?

☐ ☐

If yes, do you currently have any metal plates/pins or screws in place?

YES NO Have you had any foot or ankle problems/injuries?

☐ ☐

If yes, please specify:

YES NO Have you had any knee or hip problems/injuries?

☐ ☐

If yes, please specify:

YES NO Have you had any shoulder/elbow or wrist problems/injuries?

☐ ☐

If yes, please specify:

YES NO Have you had any other muscle/ligament or tendon problems/injuries?

☐ ☐

If yes, please specify:

YES NO Have you had any neck problems/injuries (e.g. whiplash)?

☐ ☐

If yes, please indicate the date:

YES NO Have you had any low back problems/injuries?

☐ ☐

If so, please indicate the date the date/s of your first and any subsequent episodes:

YES NO Are you currently off work due to pain or disability?

☐ ☐

If yes, how long have you been off?

YES NO Have you been diagnosed as hypermobile (excessive joint mobility)?

☐ ☐

Please list any other fitness or sports training you are doing, include the frequency:

YES NO Do you feel your work contributes to your symptoms?

☐ ☐

YES NO Have you had any recent investigations (X-ray/MRI-scans or blood tests)?

☐ ☐

YES NO Do you have any relevant reports or referrals to provide us with in relation to your treatment?

☐ ☐

YES NO Are you taking any medications not already mentioned in this questionnaire?

☐ ☐

YES NO Is there a history of ill health (heart disease, cancer, diabetes) in your family? (Including parents, grandparents, siblings)

☐ ☐

Please print any additional comments here:

What are your reasons for taking up pilates?

What health or physical goals would you like to achieve in the next three months?

What longer term health or physical goals would you like to achieve in the next 12 months?

PART 5 : Important Information(To be done by hand)

Please advise us before commencing any session if, for any reason, your health or your ability to exercise changes.

It is inadvisable to do Pilates between weeks 8 to 14 of pregnancy, unless by special arrangement with you teacher. It is also wise to wait six weeks after birth before resuming exercise.

Pilates exercises are very safe but, as with all forms of physical exercise, it is prudent to consult your doctor before starting Pilates sessions.

These sessions are not a substitute for medical counselling or treatment. If you have any doubts about the suitability of these exercises, you should refer back to your medical practitioner. The teacher can accept no liability for personal injury related to participation in a session if:

- your doctor has, on health grounds, advised you against such exercise.
- you fail to observe instructions on safety or technique.
- such injury is caused by the negligence of another participant in the class/studio.

Exercise should be performed at a pace which feels comfortable for you. PAIN is the body's warning system and should NOT BE IGNORED. Please inform your teacher immediately if you any discomfort during a session. Please also inform the teacher if you felt any discomfort after a previous session.

I understand that these exercises involve hands-on correction and I hereby consent for my teachers to work in this way.

I confirm that I have read and understood the above advice and that the information I have given is correct. I confirm that my teacher may use the contents of this form, and any other information I may later provide, for teaching purposes, and that this information;

*will be used in confidence and stored securely

• will not, in any circumstances, be shared with a third party without my written consent, unless that party is another (Body Control) Pilates teacher who will teach me.

• may be retained by the teacher for a period of time such as complies with professional, legal and insurance requirements that they must fulfil I confirm agreement for my teacher to contact me with information on classes and other Pilates-related activities, and understand that I have the right to withdraw this 'consent to be contacted' at any time.

Client _____ Date _____

Teacher _____ Date _____