

Pilates Orientation

Date/Time: _____

Pilates Instructor: _____

Personal Information:

Last Name: _____

First Name: _____

Phone: (Eve) _____ (Day) _____ Email: _____

Gender (check one): Male Female Age: _____

Occupation: _____ Date of Birth _____

Person to contact in case of an emergency: Name _____ Phone _____

What type of movement/workout have you experienced? dance yoga martial arts
 running walking swimming aerobics weight training sports (please list)

What regular activities do you do now? _____

How often? _____

What are your best days to workout (check all that apply):

- Mon. Tues. Wed. Thurs. Fri. Sat. Sun.
 Early Morning Mid-morning Noon Mid-afternoon Evening

Exercise History (please answer all questions):

- Yes No 1. Has your doctor ever said you have heart trouble?
 Yes No 2. Do you frequently have pains in your heart or chest?
 Yes No 3. Do you often feel faint or have spells of dizziness?
 Yes No 4. Has a doctor ever said your blood pressure was too high?
 Yes No 5. Has your doctor ever told you that you have a bone or joint problems such as arthritis, which has been aggravated by exercise or might be made worse with exercise?
 Yes No 6. Is there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to?
 Yes No 7. Are you over the age 65?
 Yes No 8. Are unaccustomed to vigorous exercise?

Notes: _____

Health History (please answer all questions):

Have you ever or do you currently have the following:

Orthopedic (Injury To or Pain In):

- | | | | |
|--|---------------|--|------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Neck or Spine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Knees |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Shoulders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ankles |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Elbows | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lower Back |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Wrists | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Hips | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scoliosis |

Explain: _____

Cardiovascular Risk:

- | | | | |
|--|----------------------|--|---------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cigarette Smoking | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes Mellitus |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty Breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chest Pain |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sedentary Lifestyle |

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