

# 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 |





NAME: \_\_\_\_\_

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