HEALTH SCREENING

PLEASE FILL OUT THIS FORM TO THE BEST OF YOUR ABILITIES AND SIGN THE STATEMENT AT THE BOTTOM OF THE FORM. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK.

Last Name:_____ First Name:_____

Phone number:_____

Gender:_____ Age:_____ Marital Status:_____

Hobbies/Recreational Activities and Frequency:_____

_____

Previous Experience with Pilates/Gyrotonic:_____

General Health (Check): ____Excellent ____Good ____Fair ____Poor

Personal Fitness Goals:_____

_____

Are You Currently Experiencing Any Physical Problems? If So, Please Explain:_____

_____

Medications:_____

Previous Injuries:_____

Previous Surgeries:_____

Are You Currently Receiving Professional Health Care Services (i.e. Chiropractic, Medical, Massage Therapy, Physical Therapy, Etc...):_____

_____

Are You Currently or Have You Previously Been Diagnosed with any of the Following (please check all that apply):

- ☐ Arthritis
- ☐ Back Pain
- ☐ Bowel/Bladder Changes
- ☐ Cancer
- ☐ Circulatory Disease
- ☐ Diabetes
- ☐ Dizziness
- ☐ Fainting Disorder
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Herniated Disk
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Hyperglycemia
- ☐ Numbness or Weakness
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Osteoarthritis
- ☐ Pregnancy (currently)
- ☐ Seizure Disorder
- ☐ Shoulder Impingement
- ☐ Stenosis
- ☐ Thyroid Disorder

Other:_____

Is There Anything Else That You Feel We Should Know About or Have Not Asked? If So, Please Explain:_____

I, THE UNDERSIGNED, DO HEREBY CERTIFY THAT I HAVE COMPLETED THE ABOVE INFORMATION AND KNOW IT TO BE TRUTHFUL AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature:_____ Date:_____