**Pilates Health Screening Form**

*Please complete pages 1 and 2*

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| --- | --- |
| **Name** | |
| **Date** | **Tel no** |
| **DOB** | **Email** |
| **Address** | |
|  | |
| **Name & Address of GP Surgery** | |
|  | |

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| **Do you have any known medical conditions and/or allergies? Yes / no** |
| *If yes please give details (e.g. condition, main symptoms and any health limitations).* |
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**Do you regularly take any medication?**

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| *If yes please give name of medications and reasons for taking.* |
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**Lifestyle/Health Questionnaire**

Medical Check

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| --- | --- |
| 1. Has a doctor or medical professional ever told you that you have high blood pressure? | Yes/No |
| 1. Do you ever get chest pains or feel dizzy during physical activity? | Yes/No |
| 1. Has a doctor or medical professional ever told you that you have aheart condition? | Yes/No |
| 1. Do you get out of breath easily or wake up breathless at night? | Yes/No |
| 1. Do you suffer from fainting or unexplained palpitations? | Yes/No |
| 1. Do you ever experience a tight chest or unexplained cough after strenuous activity? | Yes/No |
| 1. Are you pregnant or have you given birth within the last 6 months? | Yes/No |
| 1. Do you suffer from back pain, joint pain or a musculoskeletal condition? | Yes/No |

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| *I confirm the information I have provided is correct to the best of my knowledge. I will notify my instructor if my health changes whilst I am exercising under her guidance. I also give my consent to taking part in her exercise classes.*  **Client Signature** |
| **instructor Signature** |

Please tick the following:

I consent to my information being used to contact me about my appointment

I consent to my information being used to keep me updated about new services, offer and discounts

Notes: