CONNECT

PILATES • PHYSICAL THERAPY • COREALIGN

To ensure you receive the best possible care, please take the time to fill out this health history. If you do not understand a question, leave it blank and we will assist you.

Name_____ Date of Birth:_____

Street Address:_____

City:_____ State:_____ Zip: _____

Email address:_____
(for internal use only!)

Phone Number:_____

Occupation: (past or present)_____

Emergency Contact: Name_____ Relationship_____

Phone_____ Alternate Phone_____

Whom may we thank for your referral? _____

Please check any of the following whose care you are under:

- ☐ Medical Doctor (MD)
- ☐ Osteopath
- ☐ Dentist
- ☐ Psychiatrist/Psychologist
- ☐ Physical Therapist
- ☐ Chiropractor
- ☐ Personal Trainer
- ☐ Nutritionist
- ☐ Massage Therapist

If you have seen any of the above in the past three months, please briefly describe for what reason *(illness, medical condition, physical, etc.)*: _____

_____

_____

Have you had any prior experience with Pilates? YES ◯ NO ◯

Describe the reason you are seeking our services today: _____

_____

_____

_____

List three goals related to your participation in our exercise classes.

1. _____
2. _____
3. _____

Do you exercise regularly? YES ◯ NO ◯

If YES, how many days/week? _____ Activities? _____
_____

How much water do you drink each day? _____

On a scale of 1-10 what is your energy level? _____

In the past 3 months have you had, or do you experience:

- ☐ A general change in your health?
- ☐ Difficulty swallowing?
- ☐ Shortness of breath?
- ☐ Any type of infection?
- ☐ Fever/ chills/sweats?
- ☐ Numbness or tingling?
- ☐ Changes in appetite?
- ☐ Change in bowel/bladder function?
- ☐ Dizziness?
- ☐ Nausea/ vomiting?
- ☐ Unexplained weight change?

Past Medical History: Have you or any immediate family member *(parent, sibling, child)* ever been told you have:

	You	Family Member		You	Family Member
Allergies	☐	☐	High Blood pressure	☐	☐
Anemia	☐	☐	Joint replacement	☐	☐
Arthritis or arthritic condition	☐	☐	Kidney disease	☐	☐
Asthma, hay fever	☐	☐	Osteoporosis	☐	☐
Lung or breathing problems	☐	☐	Peripheral Vascular Disease	☐	☐
Cancer	☐	☐	Pacemaker	☐	☐
Chemical dependency (alcohol/drugs)	☐	☐	Prostate Problems	☐	☐
Circulation Problems	☐	☐	Shortness of breath	☐	☐
Cirrhosis/liver disease/hepatitis	☐	☐	Stroke	☐	☐
Diabetes	☐	☐	Skin Problems	☐	☐
Depression	☐	☐	Thyroid problems	☐	☐
Eating disorder	☐	☐	Varicose Veins	☐	☐
Heart problems	☐	☐			

Women: Are you (or could you be) pregnant? _____
Number of children: _____ Vaginal ◯ or Caesarian ◯ birth?

_____ _____ _____
Client Name Signature Date