New Strength
PILATES

Health History Form

Welcome to New Strength Pilates Studio where our goal is to help you build a strong, stable and flexible body for LIFE! Please complete this form so that we can provide the safest and most effective exercise program with your specific needs in mind.

First _____ Last _____

Email _____

Address _____

_____

Cell Phone _____ Alternate Phone _____

Best way to reach you (circle one): **Text** **Email** **Phone**

Date of birth _____ Occupation _____

Height _____ Weight _____

Emergency Contact

Name _____ Relationship _____

Phone _____ Email _____

Health History

Rate your health (circle one): **Excellent** **Good** **Average** **Needs assistance**

Physician _____ Phone _____

Medications:

Type _____What for _____

_____What for _____

_____What for _____

/continued over

Do you now have or have had in the past (please circle):

History of heart problems, chest pain or stroke: **Yes No** Diabetes: **Yes No**
Increased blood pressure/low blood pressure: **Yes No** Thyroid condition: **Yes No**

Osteoporosis: **Yes No** Osteopenia: **Yes No**

Any chronic illness or condition: **Yes No** Details _____

Recent surgery (last 12 months): **Yes No** Details_____

Pregnant (now or in last 3 months): **Yes No** Past C-section births: **Yes No**

Health History continued

List any injuries, illnesses and/or significant medical treatments. Please check all that apply and, where appropriate, specify Right (R) or Left (L):

Neck _____ Shoulder _____ Upper Back _____ Middle Back _____ Lower Back _____

Ribs _____ Hip/pelvis _____ Abdomen _____ Ankle/foot _____ Knee _____

Wrist _____ Elbow _____

Please elaborate on any of the above _____

_____

Exercise

Current physical activity and/or sports:

Type_____ How often _____

_____ How often _____

Previous Pilates experience: **Yes No**

Any difficulties with physical activity: **Yes No** If so, please elaborate _____

_____

Any physical restrictions given by physician or physical therapist: **Yes No**

Any previous injury still affecting you: **Yes No**

Do you have a hernia or any condition aggravated by weight resistance: **Yes No**

Please elaborate on any 'yes' answers: _____

_____

Signature _____ Date _____