Cores & Effect Pilates

Client Medical Assessment Questionnaire

Title Mr/Mrs, Miss/other:

First Name:

Last Name:

Address:

Postal Code:

Home Tel:

Work Tel:

Mobile:

E-mail:

Date of Birth:

Occupation:

Age:

How did you hear about us? (friend, GP or Physio etc).

Referred by: _____

Will this be the first time you have practiced Pilates?

If you have done Pilates before please indicate: Studio Matwork Indicate number of classes attended 0-10, 10-20,20 plus.

Are you on any medication that may affect you during the session?

Are you pregnant or have been pregnant in the last six month?

What is your exercise history (ie: when did you last exercise and what activity was it)?

Emergency Contact:
Name
Contact Number
Relationship to
Client

Health History: Please indicate conditions experienced presently or in the past.

Are you injured? Yes No If so have you been cleared by a doctor? Yes No

Respiratory

Chronic Cough ___

Shortness of Breath ___

Bronchitis ___

Asthma ___

Emphysema ___

Pheumonia ___

Chronic Congestive

heart failure ___

Head / Neck

Vision impairment _____ ___

Hearing impairment _____ ___

Speech impairment _____ ___

Headache/Migraine _____ ___

Jaw pain (TMJ) _____ ___

Sinus problems _____ ___

Skin

Rashes / Bruise easily _____ ___

Psoriasis _____ ___

Infections / Other _____ ___

Tattoos _____ ___

Infections

Tuberculosis ___

Human Immunodeficiency Virus (HIV) ___

Hepatitis ___

Other Conditions

Do you have any joint replacements?

Loss of sensation or weakness ___

Diabetes Mellitus (onset: _____) ___

Allergies: _____ ___

(i.e. anaphylaxis or skin irritation)

Epilepsy ___

Arthritis (type & location) ___

Fibromyalgia ___

Osteoporosis ___

Gynecological conditions ___

Hemophilia ___

Digestive conditions ___

Medications: _____

_____

_____

Soft Tissue / Joint Discomfort and its Nature

Left Right

Neck _____ _____

Low Back _____ _____

Mid Back _____ _____

Upper Back _____ _____

Shoulders _____ _____

Arms _____ _____

Legs _____ _____

Knees _____ _____

Hip _____ _____

Wrist _____ _____

Hand _____ _____

Elbow _____ _____

Ankle _____ _____

Foot _____ _____

Cardiovascular

High Blood Pressure ___

Low Blood Pressure ___

Coronary Heart Disease ___

Phlebitis ___

Stroke / CVA ___

Pacemaker or similar device