PILATES EVOLVED
Fitness that fits YOU!

Health History Form

Name_____Date_____

Address_____

Age_____ DOB_____

Phone _____OK to text? Y N Email_____

Person to contact in an emergency:

Name_____ Phone_____

Physician's name_____

Physician's phone_____

Current Medications	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current health and/or orthopedic conditions: (include chronic health conditions such as diabetes, heart disease, recent surgery, arthritis, etc)

_____

_____

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_____

Do you now, or have you had in the past:	Yes	No
1. History of heart problems, chest pain, or stroke	___	___
2. Increased blood pressure	___	___
3. Any chronic illness or condition	___	___
4. Difficulty with physical exercise	___	___
5. Advice from physician not to exercise	___	___
6. Recent surgery (last 12 months)	___	___
7. Pregnancy (now or within last 3 months)	___	___
8. History of breathing or lung problems	___	___
9. Muscle, joint, or back disorder, or any previous injury still affecting you	___	___
10. Diabetes or thyroid condition	___	___
11. Cigarette smoking habit	___	___
12. Obesity (more than 20% over ideal body weight)	___	___
13. Increased blood cholesterol	___	___
14. History of heart problems in immediate family	___	___
15. Hernia, or any condition that may be aggravated by lifting weights	___	___
16. Osteoporosis or osteopenia	___	___
17. Respiratory problems (asthma)	___	___

Please explain any “yes” answers on the back.
Comments:

_____
_____
_____
_____