



Health History

Name (first and last) _____ Today's Date _____

Date of Birth _____ Email _____

Address _____

Home Phone (_____) _____ Cell Phone (_____) _____

Physician/Therapist _____ Phone (_____) _____

Emergency Contact _____ Phone (_____) _____

How did you hear about us? _____

Please answer the following questions to the best of your ability. Your responses will be kept absolutely confidential. It will help for us to design a safe, effective program for you.

For all 'yes' response, please provide additional details, including any medications you are currently taking and possible side effects. You may be asked for Medical Clearance.

1. Are you currently a smoker or a smoker who quit within the past six months? NO YES

2. Do you have any first-degree **male** relatives (ie brother, father, son) who experienced myocardial infarction (heart attack), coronary revascularization (bypass surgery) or sudden death prior to **age 55**? NO YES

3. Do you have any first-degree **female** relatives (ie sister, mother, daughter) who experienced myocardial infarction (heart attack), coronary revascularization (bypass surgery) or sudden death prior to **age 65**? NO YES

4. Do you now have any signs that might show that you have heart disease (such as pain in chest radiating to neck, jaw, and/or arms; shortness of breath at rest or with mild exertion; dizziness or fainting; unexplained ankle swelling; heart palpitations or flutter; heart murmur; unusual fatigue or shortness of breath with everyday activities)? NO YES

5. Are you currently being treated for high blood pressure? NO YES

6. Has a doctor ever told you that you have pulmonary problems (such as bronchitis, asthma or other Chronic Obstructive Pulmonary Disease)? NO YES

7. Has a doctor ever told you that you have a metabolic disorder (such as diabetes or hyperparathyroidism)? NO YES



Health History

Name (first and last) _____ Today's Date _____

8. Are you currently being treated for elevated cholesterol? NO YES

9. Has a doctor ever told you that you have Chronic Fatigue Syndrome or Fibromyalgia Syndrome? NO YES

10. Has a doctor ever told you that you have Epilepsy, Multiple Sclerosis, Parkinson's Disease or any other neurological disorder? NO YES

11. Has a doctor ever told you that you have osteoporosis or osteopenia? NO YES

12. Have you had surgery in the past 12 months? NO YES

Please describe:

13. Are you currently or have you been pregnant in the past 3 months? NO YES

Due Date or Last date of pregnancy:

Any additional history, or issues you are currently experiencing, not addressed by this form:

Please describe your current fitness routine:

Occupation / Hobbies:

Primary Interest(s):

Pilates Personal Training Pre/Postnatal Performance Golf _____

Signature (parent/guardian if less than 18) / Date: _____

Witness Signature / Date: _____