



Pilates Health Questionnaire

Please send your completed form, course booking and post-dated payment to:

Clare Tilley, The Margates, Hollowmoor Heath, Great Barrow, Chester, Ch3 7LF

The aim of the questionnaire is to gather background information about yourself and your general health prior to your Pilates Assessment. All information will be treated confidentially. The questionnaire should take no longer than 10 minutes to complete (please ensure all sections are filled in). All information will be treated in the strictest confidence

Your Details
Name:.....
Address:
.....
Postcode:
Date Of Birth:
Telephone (Home):
Telephone (Work/Mobile):
E-mail:
GP Name & Address:.....
.....
Consultant Name & Hospital (if applicable):
How did you hear about us?



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Your Lifestyle

What is your Occupation?

Does your occupation involve any repetitive movements / activities or postures such as predominantly sitting / desk based / lifting / bending or similar. Please explain:

.....
.....

What sports & hobbies are you involved in?

.....
.....

Have you had to discontinue or modify your sports or hobbies for any health reason? Yes No

No

If 'yes' please provide details:

.....

Purpose of Pilates

Have you ever practiced Pilates before? What style (e.g. Body Control) and for how long?

.....
.....

What is your purpose for doing Pilates?

.....

What health or physical goals do you hope to achieve by practising Pilates?

.....

Have you been referred to Pilates by a specialist health practitioner? If so, by whom?

.....
.....

What aspect of your health would you like Pilates to concentrate on? Please tick the appropriate box(es):

Core Stability

Strength

Flexibility

Stress Management

Relaxation

Posture

Other (please specify)



Your Health			
Are you currently experiencing any of the following conditions?			
	Yes	No	If 'yes' please explain.
Lower back pain?	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic Pain?	<input type="checkbox"/>	<input type="checkbox"/>
Any other spinal condition?	<input type="checkbox"/>	<input type="checkbox"/>
Any other orthopaedic condition?	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
High or low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy (Grand Mal seizures)?	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy			
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
What is the due date?			
If you have had a baby in the last year, when?			
If so, was the delivery normal/caesarean?		
Back pain			
Have you ever had an episode of low back pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If 'yes', how many previous episodes of low back pain have you had?			



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Injuries and surgery	
Have you had any recent injuries or surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'yes', please give details.
Illnesses	
Please circle any of the following conditions that you have been diagnosed with or have had treatment for:	
Asthma	Osteoarthritis
Bronchitis	Cancer
Stroke	Dermatitis
Diabetes	COPD
Depression	Osteoporosis
Have you ever had any other major illnesses not included above?	
.....	
Joint Disorders	
Do you have any pain or restricted movements in any joints e.g. hip or knee?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'yes', please give details.
Do you suffer from any bone or joint problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'yes', please give details.
Have you ever been diagnosed with hypermobility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'yes', please give details.
Neck Problems	
Do you get headaches frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'yes', please give details.
Do you lose your balance because of dizziness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'yes', please give details.
Do you suffer from pins and needles, numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No



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or weak in your muscles at all?	
If 'yes', please give details.
Medication	
Are you currently taking any medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please list.
Have you ever taken steroids?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'yes', please give details.
Have you ever taken anticoagulants, drugs to thin the blood?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'yes', please give details.
Please list any health problems that you suffer with, not already mentioned, that may affect your ability to exercise. Please expand on any of the questions above and give any further relevant details below.	
.....	



Pilates Participation Informed Consent Form

The Pilates Programme will begin at a low level and will be advanced in stages depending on my fitness level/ spinal condition. I acknowledge that it is important for me to exercise at my own rate and within my own level of comfort and ability. If at any time I am unsure of the exercise or am experiencing any discomfort/ pain, I will stop the exercise completely and inform the instructor. The Pilates Programme of exercises should only be undertaken when in the Pilates Class or when I have been given specific instructions to exercise on my own.

There exists the possibility of certain dangers when exercising. These include abnormal blood pressure, fainting, abnormal heart rhythm and in rare cases, heart attack, stroke or death. While every care will be taken, it is impossible to predict the body's exact response to exercise. I acknowledge that every effort will be made to minimise these risks, by the Pilates Health Assessment Process undertaken by my assessor, and by observation during the Pilates classes.

It is advisable to inform your GP prior to starting any new form of physical exercise. Please advise the teacher before commencing any session if, for any reason your health or ability to exercise changes.

These sessions are not a substitute for medical advice or treatment. If you have any doubts about the suitability of the exercises you should refer back to your medical practitioner. The teacher can accept no liability for personal injury related to participation in a session if:

- Your doctor has, on health grounds, advised you against such exercise
- You fail to observe instructions on safety and technique
- Such injury is caused by the negligence of another participant in the class

This information is protected in accordance with the Data Protection Act 1984.

Client Signature: _____

Date: _____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE