



PILATES MEDICAL HISTORY

Today's Date:

Name: _____ .

Address: _____ .

_____ .

Phone: _____ .

_____ .

Date of Birth: _____ **Sex:** _____ .

Occupation: _____ .

_____ .

Please check any of the following that apply: _____ .

High Blood Pressure Heart Problems _____ .

Diabetes Joint Problems _____ .

Liver Disease Fractures Cancer Smoker _____ .

Night Pain Seizures Pregnancy Scoliosis _____ .

Shortness of Breath Back Problems Chronic Illness Lordosis _____ .

Osteoporosis Recent Surgery Asthma _____ .

Please circle the types of movement you have experienced: _____ .

Dance Yoga Martial Arts Running Swimming _____ .

Aerobic Dance Team Sports Other: _____ .

Current Medications _____ **Current Therapy or Medical Care** _____ .

1. _____ 1. _____ .

2. _____ 2. _____ .

3. _____ 3. _____ .

Anything else you would like to tell us: _____ .

_____ .

_____ .

Notes: _____ .

_____ .

_____ .

_____ .