HEALTH AND MEDICAL HISTORY

NAME _____ DATE _____

EMAIL _____

EMAIL APPOINTMENT REMINDERS Y___N___

STREET_____CITY_____STATE_____ZIP_____

EMERGENCY CONTACT NAME & CONTACT INFORMATION_____

How did you hear about us? Who referred you? _____
Have you had any experience in Stott Pilates? Y N Where?_____
What do you hope to gain from practicing Stott Pilates?_____
What is your current exercise program? _____
Do you receive Massage Therapy, Rolfing, Feldenkrais Therapy, Physical Therapy or bodywork?
Y N Please describe_____
Are you presently seeing a chiropractor? Y N If yes, whom?_____
What is your occupation? What does your typical day involve physically, ie:prolonged sitting, standing, walking, bending, reaching? _____
Are you under the care of a Health Care Practitioner?Y__N___Describe_____
Please check all the following that currently apply to you:

___Allergies
___Arthritis
___Asthma
___Artificial Joints
___Back Pain
___Blood Clots
___Broken Bones
___Bulging Discs
___Bursitis
___Cancer
___Chest Pain
___Depression
___Diabetes
___Digestion issues
___Dizziness
___Edema
___Epilepsy/Seizure
___Fatigue
___Hearing Aid
___Heart Disease
___Artificial Valves
___Hernia
___Herniated Discs
___Low Back Pain
___Migraines/Headaches
___Neck Pain
___Numbness
___Osteoporosis
___Osteopenia
___Pregnant*
___*How many months?
___Sciatica
___Scoliosis
___Stenosis
___Stroke
___Thyroid
___TMJ
___Varicose Veins

Please describe any condition you answered yes _____
List ALL prescription medications and vitamin supplements:
_____
_____
_____

List all recent surgeries,hospitalizations (past 5 years):
Do you have any aches and pains, please describe nature of pain, i.e.sharp, dull, achy, numbness, tingling
_____

Pain Scale_____

List Food allergies:_____

Client's Signature_____Date_____

Instructor/Therapist Signature_____Date_____

Signature of Parent/Guardian (if client is under 18 years of age)

_____Date_____