

**Admin use**

Client reference: \_\_\_\_\_

Assessment date: \_\_\_\_\_

**Pilates quick key:  
(optional)**

Preg



Diab



Card



HBP



Osteo



Meds



Off work



Frac



Jt rep



Ca



Spin surg



Digest



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**Questionnaire** “Ensuring we understand as much about your health as you do”

PLEASE PRINT CLEARLY This questionnaire is important for your therapist's future reference. Your information will remain strictly confidential.

Title Mr/Mrs/Miss/other: \_\_\_\_\_

First name: \_\_\_\_\_

Family name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Postal code: \_\_\_\_\_

Home tel.: \_\_\_\_\_

Work tel.: \_\_\_\_\_

Mobile: \_\_\_\_\_

E-mail: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

How did you find out about us? (e.g. friend, GP or Physio)  
\_\_\_\_\_Contact person and phone number in case of emergency:  
\_\_\_\_\_  
\_\_\_\_\_Will this be the first time you have practised Pilates?  yes  no? If you have done Pilates before please indicate:1.  studio  matwork 2. number of previous classes attended:  0 – 10  10 – 20  20+ (please tick)**QUICK CHECK CURRENT HEALTH STATUS****Do you suffer from or have you been diagnosed with any of the following?****Yes****No****If yes, please give details:**  a. Are you injured? If so have you been cleared to exercise by your doctor?Yes  No  \_\_\_\_\_  b. Diabetes? Do you take medication for your diabetes? Yes  No   c. High blood pressure (HBP)? If high, are you taking diuretics, anti-hypertensives or Beta-blockers?  
\_\_\_\_\_  d. Cardiac/heart problems? If yes, have you had an exercise stress test? Yes  No   e. Epilepsy? If yes, have your seizures been stabilised on medication? Yes  No   f. Asthma or other breathing problems? Do you suffer from shortness of breath/dizziness during exercise?  
\_\_\_\_\_  g. Have you been diagnosed with osteoporosis? \_\_\_\_\_  h. Do you have any joint replacements? \_\_\_\_\_  i. Do you have any longstanding medical condition (e.g. Parkinson's, MS, ME)?  
\_\_\_\_\_  j. Do you suffer from digestive complaints (ulcers, reflux, colitis etc)? \_\_\_\_\_  k. Have you been diagnosed with any form of cancer? \_\_\_\_\_  
\_\_\_\_\_

**YOUR PREGNANCY HISTORY (WHERE APPLICABLE)****Yes      No      This section applies to anyone who is or has been pregnant**

- 1.** Are you or could you be pregnant now?  
If yes, when is your due date? \_\_\_\_\_
- 2.** Have you had any previous pregnancies?  
Please list delivery year(s): \_\_\_\_\_
- 3.** Were there any complications? \_\_\_\_\_  
\_\_\_\_\_

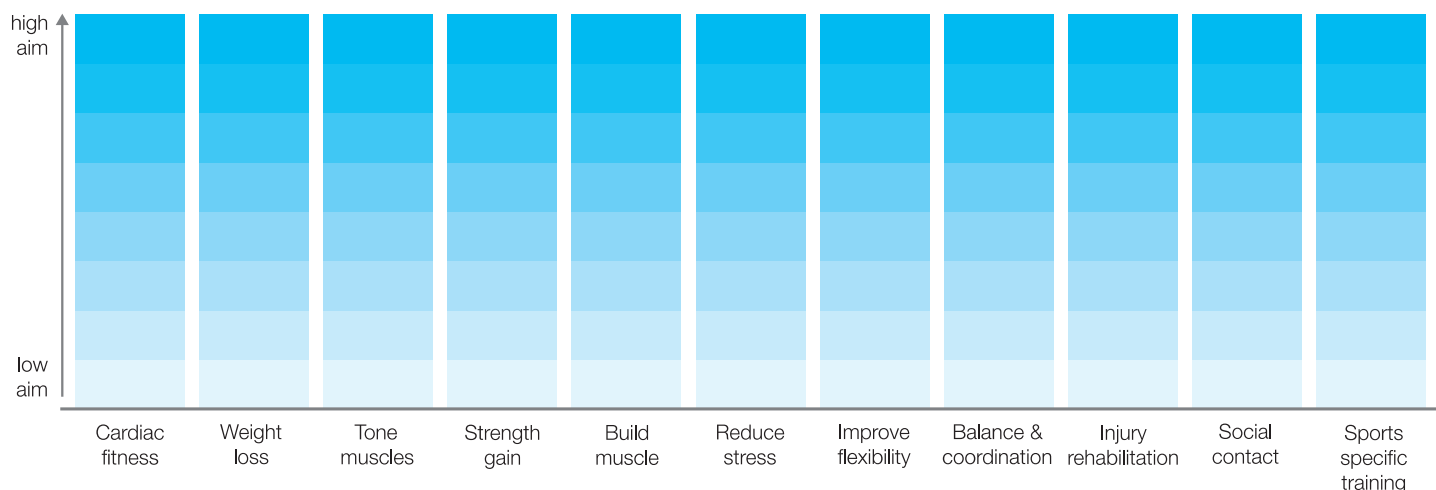
**RELEVANT PAST MEDICAL AND INJURY HISTORY****Yes      No      Where applicable please provide brief explanations below**

- a.** Have you been involved in any major accident(s) (e.g. motor vehicle accidents)?  
\_\_\_\_\_
- b.** Have you had any major surgery?  
\_\_\_\_\_  
\_\_\_\_\_
- c.** Have you had any bone or stress fracture? If yes, do you currently have any metal plates/pins or screws in place? \_\_\_\_\_  
\_\_\_\_\_
- d.** Have you had any foot or ankle problems/injuries?  
\_\_\_\_\_
- e.** Have you had any knee or hip problems/injuries?  
\_\_\_\_\_
- f.** Have you had any shoulder/elbow or wrist problems/injuries?  
\_\_\_\_\_
- g.** Have you had any other muscle/ligament or tendon problems/injuries?  
\_\_\_\_\_
- h.** Have you had any neck problems/injuries (e.g. whiplash)? If so please indicate the date: \_\_\_\_\_  
\_\_\_\_\_
- i.** Have you had any low back problems/injuries? If so please indicate the number of previous episodes:  
0-5  6-10  11+  most recent episode, date: \_\_\_\_\_  
\_\_\_\_\_
- j.** Have you been diagnosed as hypermobile (excessive joint mobility)?  
\_\_\_\_\_

**OTHER INFORMATION****Yes      No      Is there any other condition or disability not covered above that your Pilates teacher should be aware of?**

- \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

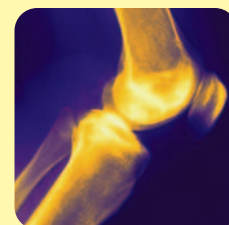
**Rate your current exercise goals** – please put a mark in each column to indicate your exercise aims



**Other goals:** \_\_\_\_\_

**ADDITIONAL RELEVANT INFORMATION**

**Yes**  **No**  **a.** Have you had any recent investigations (X-ray/MRI-scans or blood tests)?  
 results: \_\_\_\_\_



**b.** Do you have any relevant reports or referrals to provide us with relation to your treatment? \_\_\_\_\_

Treating practitioner: \_\_\_\_\_ Phone: \_\_\_\_\_

Contact address: \_\_\_\_\_

**c.** Is there a history of ill health (heart disease, cancer, diabetes) in your family?  
 \_\_\_\_\_

**d.** Do you feel your diet provides you with adequate nutrition?

**e.** i) Please rate your level of stress at home?

(no stress) 0 |-----| 10 (extremely stressed)

ii) Please rate your level of stress at work?

(no stress) 0 |-----| 10 (extremely stressed)

**f.** intake of: **cigarettes**/day \_\_\_\_\_ ; daily units (cups) **tea** \_\_\_\_\_ **coffee** \_\_\_\_\_

weekly units (glasses) of **alcohol** \_\_\_\_\_

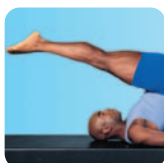
**Terms and conditions**

- The Pilates programme we devise for you is based upon our sound teaching practise and the information you have provided about yourself when filling out this medical screening questionnaire
- You must therefore inform us about any change in your medical condition as soon as you become aware of it
- If undertaking a studio/equipment-based class you should not attempt to adjust or interfere with any of the equipment unless you have had prior instruction on how to do so
- If you experience any pain or dizziness during an exercise class you should stop what you are doing and consult your doctor
- If you injure yourself in anyway during an exercise class you should inform your Pilates teacher or one of the administration staff at that time
- We accept no liability whatsoever for any injury or death unless the same is caused directly by negligence of one of our instructors
- I declare that I have filled out this questionnaire truthfully, comprehensively and to the best of my ability

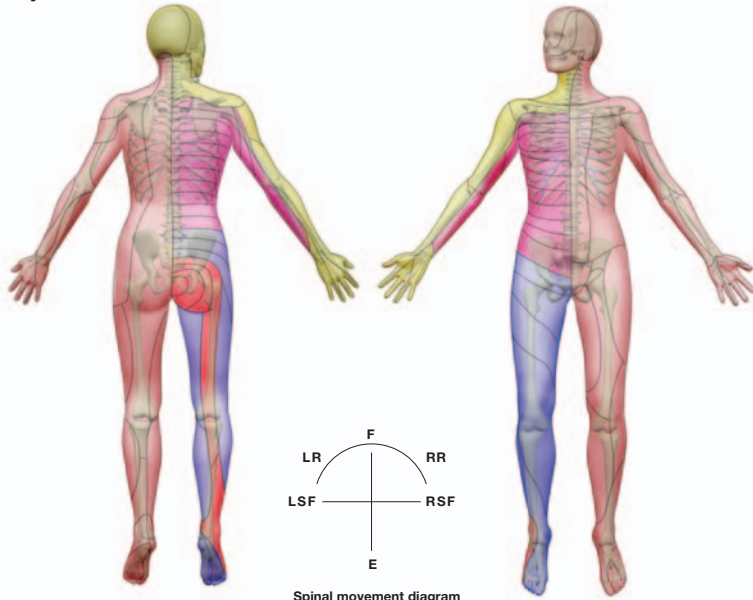
I accept the above terms and conditions and agree to abide by them:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Services provided by:



Body chart



Initial observations:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SPINAL OBSERVATIONS

| Static postural observations (at rest) | Right                 | Left                  | Neutral/normal        | Dynamic postural observations (during movement) | Right                 | Left                  | Neutral/normal        | Pain                  |
|----------------------------------------|-----------------------|-----------------------|-----------------------|-------------------------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Lateral neck shift                     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Restricted neck rotation                        | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Rotated neck                           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Restricted neck side bend                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Lateral spine shift                    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Restricted spine rotation                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Spine rotated in standing              | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Restricted spine side bend                      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Scoliosis (concave)                    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Deviation during roll down                      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Kyphosis: reduced  accentuated  normal       other: \_\_\_\_\_

Lordosis: reduced  accentuated  normal       \_\_\_\_\_

GENERAL OBSERVATIONS (problem list)

Dominant side?  right handed     left handed

Restrictions

Instabilities

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

INITIAL PILATES PLAN

Developed in association with:



to order additional forms please visit:  
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