Chris Staefe Fitness Pilates Studio
www.staefe.com
Health Screening Form

TODAY'S DATE:___________

PERSONAL INFORMATION

NAME:_______________________________________ AGE:_________ GENDER: M F
PHONE NUMBER:_______________________E-MAIL:_____________________________
MAILING ADDRESS:____
EMPLOYER:____
HEIGHT:______________ WEIGHT:______________

HEALTH HISTORY

HAVE YOU EVER BEEN TREATED BY A PHYSICIAN FOR:
(Please circle Y = Yes, N = No.)

- HEART DISEASE: Y N
- HIGH BLOOD PRESSURE: Y N
- GASTRIC REFLUX: Y N
- GLAUCOMA: Y N
- ORTHOPEDIC/JOINT (shoulder/elbow/spine/hip/knee) PROBLEMS: Y N
- OSTEOPROROSIS: Y N
- ARTHRITIS: Y N
- PERIPHERAL NEUROPATHY (numbness/tingling/diminished sensation): Y N
- ARE YOU PREGNANT? Y N
- PRIOR DELIVERIES? Y N IF YES, THEN WHEN? _________________________
- PRIOR SURGERIES? Y N IF YES, THEN WHEN? _________________________
  PLEASE LIST SURGERIES:____
  ____
  ____
- DO YOU SMOKE? Y N
- DO YOU TAKE ANY MEDICATIONS? Y N
  IF YES, PLEASE LIST:____
  ____
  ____
- DO YOU CARRY A LIST OF YOUR CURRENT MEDICATIONS? Y N
- DO YOU CURRENTLY EXPERIENCE ANY LINGERING PHYSICAL PAIN OR DISCOMFORT? Y N
  IF YES, WHERE AND HOW SEVERE (ON A SCALE OF 1-10)___________________
  ____
  ____

FITNESS HISTORY

HAVE YOU TAKEN PILATES BEFORE?   Y N   WHEN AND WHERE?___________________
____

WHICH PILATES EQUIPMENT HAVE YOU BEEN ON?________________________________
____
____

PLEASE LIST PRIOR MOVEMENT EXPERIENCE (dance, yoga, pilates, sports, etc.)_____
____
____
____
____

FITNESS GOALS:____
____
____
____

ANYTHING ELSE? ____
____
____
____

EMERGENCY CONTACT

NAME:____
PHONE NUMBER:____
RELATION:____

PRINT NAME:____

SIGNATURE:____DATE:______________

THANK YOU!

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