

**Health**

**Screening/Consultation**

**Form**

These conditions affect your ability to exercise. Please fill in those that apply to you.

**Name:**

**Age:**

**Gender:**

**Weight:**

**Weight Goals:**

**To provide you with the best Pilates or Group Class instruction, what are your current exercise goals, concern areas and long term goals?**

**Prior Movement Experience?**

**Other fitness Interests:**

**Current activity level and exercise frequency-**

1x week

2x's week

3xs week

5x's week

**Have you been treated by a Physician. please check below**

Arthritis

Diabetes

Fibromyalgia

Heart Disease

High Blood Pressure

Gastric Reflux

MS

Parkinson disease

Orthopedic/Joint Issues (shoulder/Elbow/hip/knee )

Please explain If applicable

**Hip/Knee**

Knee Injuries or surgery

Please explain if applicable

Hip Replacement

SI Joint

**Spine**

Herniated or Bulging Disc

Please indicate location

Stenosis

Osteoporosis

Spondylosis

**Other injuries of concern or issue:** \_\_\_\_\_