|  |  |
| --- | --- |
| Name: Address: Email:Telephone:Next of kin Name Contact number: | Date of Birth:Your HeightYour WeightDate: |

Date:

1. Do you have any injuries, aches or pains? (Recent or Old) Please describe them:

......................................................................................................

......................................................................................................

1. Do you have any other health concerns? E.g. asthma, diabetes, high blood pressure, or any condition for which you take medications

......................................................................................................

1. Are you presently doing any other kinds of therapy? E.g. massage, physio, chiropractic

......................................................................................................

1. Are you or were you involved in any sport or exercise programme, physical activity?

 ...................................................................................................

1. Have you had any past training in the Pilates or yoga method of movement?

 ...................................................................................................

1. What is your occupation?

......................................................................................................

1. Do you have any pelvic health issues?

......................................................................................................

1. Do you suffer from osteo/rheumatoid arthritis? If so which joints are affected?

......................................................................................................

1. Do you have any problems with your bones? (Osteoporosis or height loss)

 .....................................................................................................

1. Have you any back problems?

 .......................................................................................................

1. Can you get down to the floor unaided?

......................................................................................................

1. Is there any other information you feel the instructor would benefit from knowing?

......................................................................................................

14. Are you taking any medication? If so, please list the health conditions for which the medication is prescribed.

....................................................................................................

Please list:

Health Conditions. Medications.

1.
2.
3.
4.
5.