

Today's Date: _____

ACTIVE BODY History Form

Please feel free to only answer the questions that you think may be important for me to know.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Business/Cell phone: _____

E-mail Address: _____

Emergency Contact Phone: _____ Relationship: _____

Date of Birth: _____ Weight: _____ Height: _____

In order to design a safe and effective fitness program it is important that you complete the following Health History. It is crucial that you answer all the questions honestly and to the best of your ability. *Please be advised that all information is kept strictly confidential.*

A. Check the appropriate response. Read all questions thoroughly. YES NO

- | | | |
|---------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Has your doctor ever told you that you have heart problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has your doctor ever told you that you have high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had a stroke or heart attack? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had pain in your chest? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you ever feel faint or have dizzy spells? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had surgery in the last 6 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you been pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| Given birth how many times? _____ Cesarean Births? _____ | | |
| 8. Do you smoke? If yes how much? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

B. Check the appropriate conditions.

- | | | |
|-----------------------------------|------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Blood Pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Pregnancy | |

C. Have you injured or have pain in the following areas? Check the appropriate box.

- | | | |
|---------------------------------|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Neck | <input type="checkbox"/> Upper Back | <input type="checkbox"/> Shoulders |
| <input type="checkbox"/> Elbows | <input type="checkbox"/> Lower Back | <input type="checkbox"/> Hips |
| <input type="checkbox"/> Wrists | <input type="checkbox"/> Knees | |

If yes please explain: _____

D. Are you Right handed or Left handed? _____

E. What is your general health status? Not Very Healthy Healthy w/ some concerns
 Healthy w/ no concerns Very Healthy

F. Have you experienced any major life changes in the past year? (divorce, move, birth etc.) _____

G. Are you currently taking any medications? Yes No

If you checked Yes please list medications, dosage, and for what condition.

Medication _____	Dosage _____	Condition _____
Medication _____	Dosage _____	Condition _____

H. Have you had any past training in Pilates? Yes No

If yes when and where?

I. What is your occupation? _____

What does your typical day involve physically? (sitting, lifting, computer etc.)

J. Are you currently undergoing treatment from any of the following?

- | | | |
|------------------------------------------|---------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Physiotherapist | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Massage Therapist |
| <input type="checkbox"/> Other _____ | If yes why? _____ | |

K. What is your current exercise level?

- | | | |
|-------------------------------|---------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> 2-3 times per week | <input type="checkbox"/> 4-5 times per week |
|-------------------------------|---------------------------------------------|---------------------------------------------|

If yes what type?

L. How would you rate your level of stress on a daily basis?

- | | | |
|------------------------------|-----------------------------------|-------------------------------|
| <input type="checkbox"/> Low | <input type="checkbox"/> Moderate | <input type="checkbox"/> High |
|------------------------------|-----------------------------------|-------------------------------|

M. Are you currently following any type of special diet? Please check appropriate lines.

- Reduced Calorie Increased Calorie Low Fat
 Low Cholesterol Low Salt Other _____

N. What are your goals for Pilates? Number the following exercise benefits according to their importance for you. (One being the most important)

- Weight Loss _____ Weight Gain _____ Stress Reduction _____
Increase Flexibility _____ Increase Strength _____ Posture _____
Spinal Rehabilitation _____ Cardiovascular Conditioning _____ Other _____

O. Estimate how many hours of sleep you get each night: _____

P. Are there any other reasons (health or personal) that may prevent or limit you from exercising? _____

Q. What helps motivate you? _____

Print Name: _____ Date: _____

Signature: _____

Instructor: _____