1.

Admin use
Client reference:

Assessment date:

prePilatesAssessment

©The medical assessment questionnaire for your clients

studio & private

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? ___________

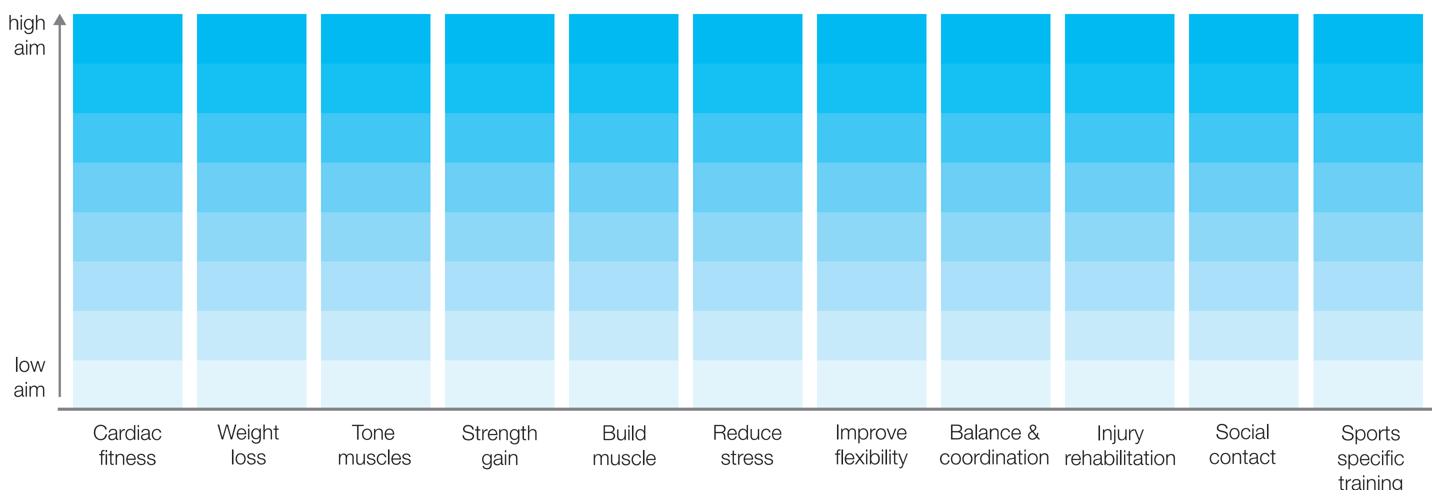
RELEVANT PAST MEDICAL AND INJURY HISTORY

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

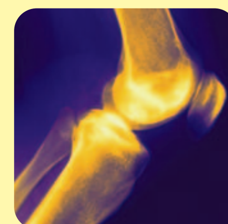
Yes	No	
◯	◯	**Is there any other condition or disability not covered above that your Pilates teacher should be aware of?** ___________

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** _____

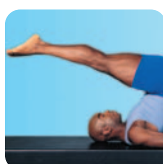
Terms and conditions

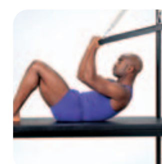
- The Pilates programme we devise for you is based upon our sound teaching practise and the information you have provided about yourself when filling out this medical screening questionnaire
- You must therefore inform us about any change in your medical condition as soon as you become aware of it
- 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

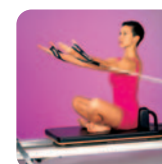
I accept the above terms and conditions and agree to abide by them:

Signed: ____________________ Date: ____________________

Services provided by:

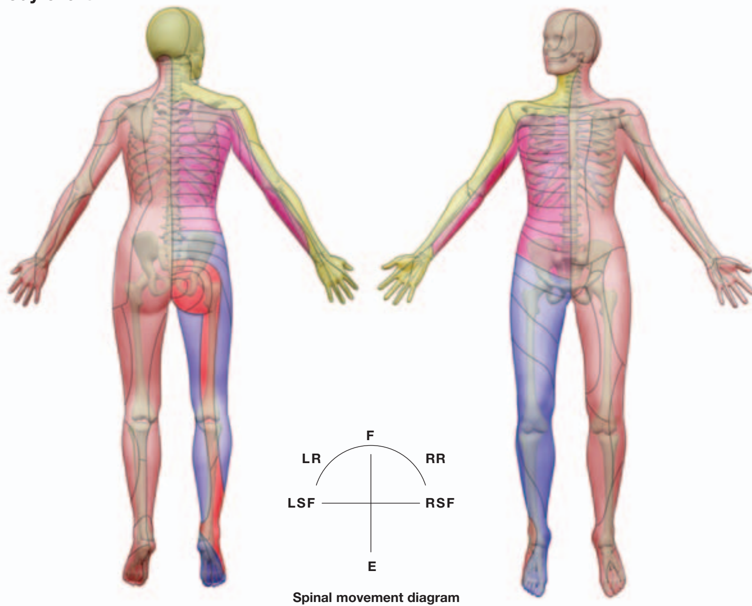






PHYSICAL ASSESSMENT – Pilates practioner only section

Body chart



Spinal movement diagram

Initial observations:

SPINAL OBSERVATIONS

Static postural observations (at rest)	Right	Left	Neutral/ normal	Dynamic postural observations (during movement)	Right	Left	Neutral/ normal	Pain
Lateral neck shift	○	○	○	Restricted neck rotation	○	○	○	○
Rotated neck	○	○	○	Restricted neck side bend	○	○	○	○
Lateral spine shift	○	○	○	Restricted spine rotation	○	○	○	○
Spine rotated in standing	○	○	○	Restricted spine side bend	○	○	○	○
Scoliosis (concave)	○	○	○	Deviation during roll down	○	○	○	○

Kyphosis: reduced ○ accentuated ○ normal ○
Lordosis: reduced ○ accentuated ○ normal ○

other:

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:
www.mystudiosoft.com
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