Pilates Journey, LLC

HEALTH SCREENING

Please help me care for you to the best of my ability by disclosing any health conditions that apply to you, past or present. Please update me with any changes in your physical condition that arise in the future. **ALL INFORMATION WILL REMAIN CONFIDENTIAL.**

Have you – **currently or in the past** – experienced any of the following:

YES	NO	
___	___	Joint discomfort or dysfunction (spine / hip / peripheral)
___	___	Muscle or soft tissue discomfort or dysfunction
___	___	Nerve tension
___	___	Osteoporosis
___	___	Arthritis (type? degree? characteristics of pain?)
___	___	Heart condition (heart disease / palpitations / chest pressure or tightness / arm pain)
___	___	Circulatory conditions (high blood pressure / stroke / aneurysm / thrombosis / phlebitis / glaucoma)
___	___	Head injury / dizziness / headaches
___	___	Peripheral neuropathy (tingling / diminished sensation / numbness)

___ ___ Respiratory irregularities (asthma / shortness of breath)

___ ___ Diabetes

___ ___ Pregnancy

___ ___ Hernia / prolapse / incontinence

___ ___ Other chronic conditions

___ ___ Have you been examined by a licensed health practitioner within the past 12 months?

___ ___ Do you regularly take any medications?

___ ___ Do you undergo any treatment directed by a physician?

___ ___ Have you been hospitalized or had surgery?

___ ___ Have you ever been advised to avoid exercise?

___ ___ Do you receive any alternative therapy (physical therapy / manual therapy / massage)?

I fully understand the Pilates Journey LLC health screening and have completely and truthfully answered each question. I agree to disclose any changes in my health that arise in the future.

_____ _____

Signature Date

_____

Printed name