Livepilates Health Screening Form

Name:..

Age: .... Sex: M F Date of Birth: ....

Address: ....

.... Mobile Nos: ....

Home Telephone .... E-mail Address: ....

Number and person to call in case of emergency:

....

MEDICAL HISTORY:
Please answer the following questions by circling the appropriate, and/or writing in the additional space.

A. Are you taking any prescribed medication:
Yes No

Have you been hospitalised recently:
Yes No

B Are you pregnant:?
Yes No

Have you given birth in the past 6 weeks?
Yes No

If YES, was it by normal delivery or Caesarean section? ....

C Do you have or have you ever had?

Arthritis	Asthma	Muscular Pain	Cramps
Yes No	Yes No	Yes No	Yes No

If you have answered yes please give more details below:

....

....

....

....

D Do you have any pain or major injuries, particularly in the following areas?

Neck	Back	Knees	Ankles
Yes No	Yes No	Yes No	Yes No

If you have answered yes please give more details below:

....

....

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If you feel there is any further information about your medical background that would be relevant to Pilates please fill out below:

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....

....

DECLARATION:

I fully understand what is involved in taking part in this livpilates course and do so of my own free will. Any questions that I have about the course have been answered to my full satisfaction.

Signed: ....

Print name:...

Date: ....

CONFIDENTIALITY

Please note that your Pilates pre-exercise questionnaire is confidential and will only be used by the relevant qualified instructor