

East End Movement

Shop 1, 1 Moroney Avenue Newcastle East NSW 2300



Pilates Client Health History

Date _____

Name: _____

Address: _____

Telephone: (m) _____ (h) _____

Email address: _____

Date of Birth: _____ Occupation: _____

Do you have Private Health Insurance? _____ Health Fund: _____

Referred by: _____

How did you hear about us? (Please Circle)

Internet Search Friend Brochure Sign Website Facebook Referral Flyer

What is your primary complaint? _____

When did you first notice symptoms? Cause? _____

Describe your symptoms _____

What activities or movements *aggravate* your symptoms?

What activities or movements *relieve* your symptoms?

Has there been a previous diagnosis? _____

Does your condition interfere with? (Please Circle)

Work Sport Daily Life Sleep Social Activities

Have you ever suffered from any of the following conditions? (Please Circle)

Heart Problems	Yes No	Anxiety	Yes No
High/Low Blood Pressure	Yes No	Insomnia	Yes No
Varicose Veins	Yes No	Headaches	Yes No
Blood Clots	Yes No	Migraines	Yes No
Stroke	Yes No	Fatigue	Yes No
Skin Disorders	Yes No	Depression	Yes No
Allergies	Yes No	Seizures	Yes No
Cancer/Tumors	Yes No	Accident/Trauma	Yes No
Asthma	Yes No	Neck Problems	Yes No
Hernia	Yes No	Other Injury	Yes No
Digestive Problems	Yes No	Osteoporosis	Yes No
Arthritis	Yes No	Chronic Pain	Yes No
Numbness/Tingling	Yes No	Fibromyalgia	Yes No

Are you pregnant? (Please Circle) Yes No Weeks/Months? _____ Due Date? _____

Please list *any* previous surgeries, hospitalisations or accidents

Please list any medications taken currently

Med #1 _____ Reason _____

Med #2 _____ Reason _____

Med #3 _____ Reason _____

Do you have any internal pins, wires or artificial joints? _____

Have you seen any other practitioner regarding this complaint? (Please Circle) Yes No

GP Specialist Physiotherapist Chiropractor Podiatrist Massage Therapist

I _____ declare the information I have provided is true and correct to the best of my knowledge.

I agree to inform the instructor if there are any changes in my medical state before commencing or continuing a class. I agree to participate in the class under the instructor's guidance.

I acknowledge the above information will be kept confidential and used as a guideline to the limitations of my ability to exercise.

I understand the Cancellation Policy, and that I must provide at least 24 hours notice of cancellation of a class. I understand that I may be charged the full fee for a missed appointment if proper cancellation notification is not provided to the clinic.

I do not wish to receive email updates, promotions or newsletters in the future

Client Name _____ Signature of Client/Guardian _____

Instructor Name _____ Date Signed _____