PILATES MEDICAL HISTORY

Today's Date:

Name:

Address:

Phone:

Date of Birth: **Sex**:

Occupation:

Please check any of the following that apply:

High Blood Pressure	Heart Problems		
Diabetes	Joint Problems		
Liver Disease	Fractures	Cancer	Smoker
Night Pain	Seizures	Pregnancy	Scoliosis
Shortness of Breath	Back Problems	Chronic Illness	Lordosis
Osteoporosis	Recent Surgery	Asthma	

Please circle the types of movement you have experienced:

Dance	Yoga	Martial Arts	Running	Swimming
Aerobic Dance	Team Sports	Other:		

Current Medications	**Current Therapy or Medical Care**
1.	1.
2.	2.
3.	3.

Anything else you would like to tell us:

Notes: