Client Health History

BODIES IN BALANCE
THERAPEUTIC PILATES

206.783.5919
By appointment

PO Box 30003
Seattle, WA 98113

NAME AGE M\F

ADDRESS BIRTHDATE

CITY STATE ZIP

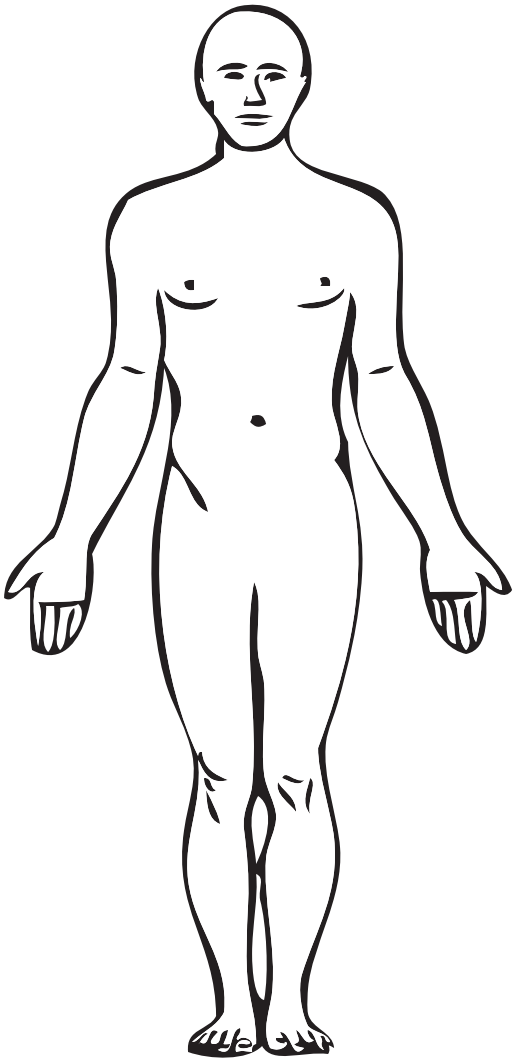
OCCUPATION

WORK PHONE HOME PHONE

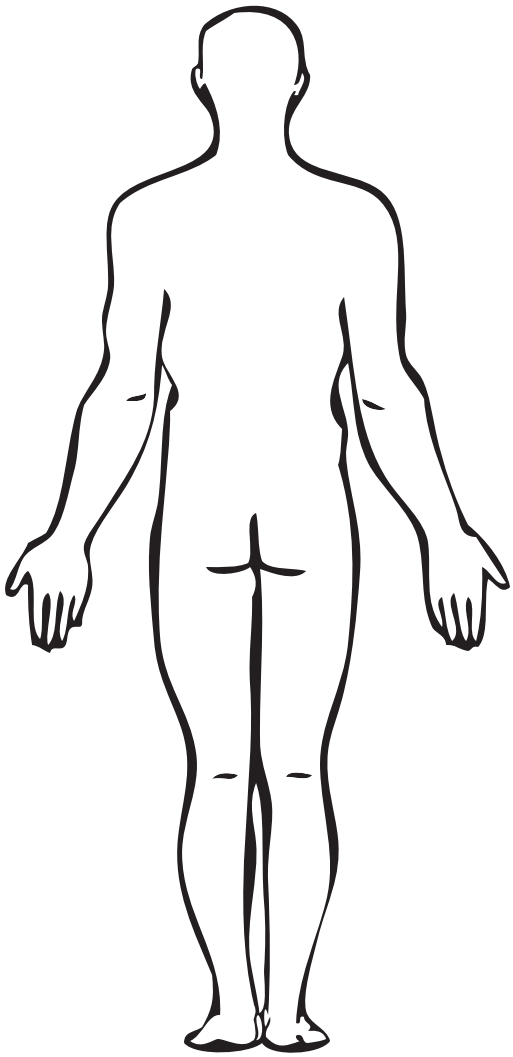
CELL PHONE EMAIL

REFERRED BY

Mark any areas of current pain or issues you are dealing with or want to address on the figures below:



R FRONT L



L BACK R

YES NO Do you take any prescribed medications? Please list:

YES NO Do you take any over-the-counter medications? Please list:

YES NO Do you have any allergies? Are you taking any medications for them? Please list all medications:

YES NO Do you have, or have you ever had, a heart or lung problem? Breathing problem or seizures? Please explain:

YES NO Have you ever been advised by a doctor to avoid exercise? Please explain:

YES NO Do you have any orthopedic problems (bone, joint, ligament, tendon, muscle)? Please explain:

YES NO Do you have any type of arthritis, bursitis or tendinitis? Please explain:

YES NO Do you have, or have you ever had, back pain or problems (i.e. herniated disks)? Please explain:

YES NO Are you under an extreme amount of stress? Please explain:

YES NO Do you have, or have you had, any injuries (including minor)? Please describe and give date:

YES NO Have you had any surgeries? Please describe and give dates:

YES NO Have you had any pregnancies? Number:_____ Vaginal delivery: _____ Cesarean: _____

What exercise do you currently do on a regular basis? Please be specific, giving frequency and duration.

What are your main reasons and goals for enrolling in this program?

THANK YOU!