Corestar Pilates
The Essence of Well Being

Health History

Last Name _____ First Name _____

Street _____ Apartment # _____

City _____ State _____ Zip _____

Phone _____ Email _____

In order to design a safe and effective program it is important that you complete the following health history form. It is crucial that you answer all the questions honestly and to the best of your ability.
Please be advised that all information is kept strictly confidential.

Please check the appropriate response.

	Yes	No
1. Has your doctor ever told you that you have heart problems?	☐	☐
2. Has your doctor ever told you that you have high blood pressure?	☐	☐
3. Have you ever had a stroke or heart attack?	☐	☐
4. Have you ever had pain in your chest?	☐	☐
5. Do you ever feel faint or have dizzy spells?	☐	☐
6. Have you had surgery in the last 6 months?	☐	☐

Check the appropriate conditions.

☐ Diabetes
☐ Asthma
☐ Heart Problems
☐ Epilepsy
☐ Arthritis
☐ Pregnancy
☐ High/Low Blood Pressure
☐ High Cholesterol
☐ Other _____

Have you injured or have pain in the following areas?

☐ Neck
☐ Elbow
☐ Wrists
☐ Upper Back
☐ Lower Back
☐ Knees
☐ Shoulders
☐ Hips
☐ Other _____

If yes, please explain. _____

Are you currently taking any medications?

Are you currently undergoing treatment for any of the following?

☐ Physical Therapist ☐ Chiropractor ☐ Massage Therapist
☐ Other

If yes, please explain.

What is your current exercise level?

☐ None ☐ 2-3x per week ☐ 4-5x per week

What types of exercise?

What are your exercise goals? (posture, strength, weight loss, etc.)

What is your occupation? What does your typical day involve physically?
(sitting at a computer, lifting, etc.)

Printed Name: Date:

Signature:

Instructor: