



Northants  
Pilates

PLEASE PRINT CLEARLY.

Any information about you contained on this form will remain strictly confidential.

Home Tel: \_\_\_\_\_ Daytime Tel/mobile: \_\_\_\_\_

Title: \_\_\_\_\_ First Name: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Post Code: \_\_\_\_\_

How did you hear about us?  
(e.g. friend, GP or Physio) \_\_\_\_\_

**Contact name and phone number/s in case of emergency**



Please tick ALL that apply

1. Does your work involve any of the following?

- Sitting for long periods
- Driving
- Pc/keyboards
- Bending
- Lifting heavy weights
- Standing
- Any other repetitive action \_\_\_\_\_

3. Has your doctor ever said that you have any sort of heart trouble or defect?

- Yes
- No

7. Is your blood pressure :

- Low
- Normal
- High
- Don't know

2. Will this be the first time that you have practised Pilates?

- No
- Yes

4. Do you feel pain in your chest, or get short of breath when you do physical activity?

- Yes
- No

8. Have you ever had any surgery?

- No
- Yes - Major
- Yes - Minor

If no, have you previously attended:

- Studio
- BCP Matwork
- Other Pilates matwork
- At home (book, DVD)

5. Do you suffer from headaches?

- Yes
- No

9. Do you suffer from asthma, diabetes or epilepsy?

- Yes
- No

Number of classes attended:

- 1-5
- 6-10
- 11-19
- 20+

6. Do you suffer from dizziness or do you ever lose consciousness, feel faint or dizzy?

- Yes
- No

10. Have you ever been told that you have arthritic joints or any bone or joint problem that may be made worse by exercise?

- Yes
- No

Over what period of time \_\_\_\_\_



# No back pain at your first visit

Please tick **ALL** that apply

11. Do you suffer from:
- Back pain  Neck pain  Neither

\_\_\_\_\_

14. Are there any movements that cause you pain?
- Yes  No
- If yes please state what movements

\_\_\_\_\_

Do you give us permission to contact them?

Yes  No

If yes, please state their name and contact number and give your authorisation by signing and dating below:

12. Do you have pain or restricted movement in any joints? (e.g. hip, knee, ankle, elbow, shoulder)

- Yes  No

If yes please give details \_\_\_\_\_

\_\_\_\_\_

15. Are you currently taking any drugs or medication?

- Yes  No

If yes please list \_\_\_\_\_

\_\_\_\_\_

Practitioner's name:

\_\_\_\_\_

Practice Telephone:

\_\_\_\_\_

Your signature:

\_\_\_\_\_

Date:

\_\_\_\_\_

13. Have you been diagnosed as hypermobile (excessive joint mobility)?

- Yes  No

16. Have you been referred to Plates by a medical specialist?

- Yes  No

## Pregnancy

1. Are you, or could you be, pregnant now?

- Yes  No

If yes, when is your due date? \_\_\_\_\_

3. Are you breast feeding?

- Yes  No

Please list any other information that may be relevant

2. Have you been pregnant in the last six months?

- Yes  No

If yes, and you went full term, how was your baby delivered?

- Normally  Caesarean

Baby's weight \_\_\_\_\_

Please use this space to give further details about any health problems ticked above, or any other health problems that you may have, that have not been mentioned so far:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

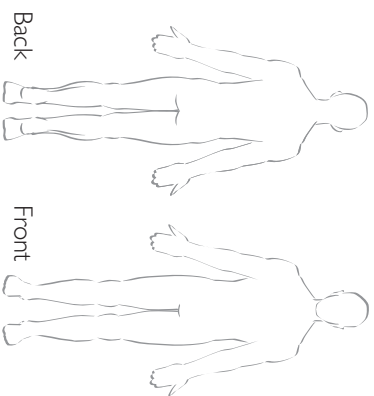
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Your body chart diagram:**



**1st. assessment observations (instructors only):**  
(e.g. rolldown, scoliosis, lordosis, kyphosis)

Blank area for recording 1st. assessment observations.



**Your symptom specification story**

**Please tick ALL that apply**

**Do you experience pain, discomfort or any other symptoms at the moment?**

Yes  No (if no, please go to the next section)

If yes, please note the painful areas with a **x** on the body chart above and answer the following questions.

1. Where are the areas of discomfort? (e.g. outside of my left knee or under my right shoulder)
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
2. When did they begin (if the result of an injury please note cause, e.g. motorcycle or skiing accident, plus date):
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
3. Is it:
  - Improving  Unchanging  Worsening
4. What makes your symptoms better (relieving factors):
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
5. What makes your symptoms worse (aggravating factors):
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
6. What makes your symptoms worse (aggravating factors):
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
7. Please list any previous treatment for these symptoms, and the outcome):
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_

**Proposed initial treatment plan (instructors only)**

Blank area for recording proposed initial treatment plan.



# Additional Referral Form

1. Have you had any recent investigations (X-ray/MRI-scans or blood tests)?  
 Yes  No
3. Please list any other fitness or sports training you are doing, indicating the frequency:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
3. Is there a history of ill health (heart disease, cancer, diabetes) in your family?  
 No  Yes

### Ongoing studio notes (instructors only):

Use the space below for additional important information that may arise during a client's attendance history.

Date: \_\_\_\_\_ Comment: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date: \_\_\_\_\_ Comment: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date: \_\_\_\_\_ Comment: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Terms & Conditions

To be signed by you prior to commencing any Pilates sessions

- The exercise programme we advise for you is based upon the information you have provided about yourself when filling out this medical screening questionnaire.
  - You must therefore inform us of any change in your medical condition as soon as you become aware of it.
  - If undertaking a studio/equipment-based class you should not attempt to adjust or interfere with any of the equipment.
  - When exercising you must follow the instructions of staff at all times.
  - We accept no liability whatsoever for any injury or death unless the same is caused directly by negligence of one of our instructors during a class.
  - I declare that I have filled out this questionnaire truthfully, comprehensively and to the best of my ability.
- I accept the above terms and conditions and agree to abide by them:

Print Name \_\_\_\_\_  
 Signed: \_\_\_\_\_

## Thank you for completing this form.

Please return completed form and return it by post, or bring it to your next class.

**Northants Pilates Ltd.** 25 Firdale Avenue, Rushden, Northants NN10 6ED  
 T: 01933 413700 E: karen@pilatesfaceandbody.com

Instructors Reference:  
[www.pilatesfaceandbody.com](http://www.pilatesfaceandbody.com)

- Preg
- Diab
- Cardio
- B.P.
- Osteo
- Med.
- Off work
- Frac
- Jt rep
- Hip rep
- Ca
- Spin surg
- Dig

Client Name: \_\_\_\_\_  
 Reference: \_\_\_\_\_