A.B.S. PILATES

Amanda B. Smith Pilates and Fitness
614-499-6770

Health History Questionnaire

(Please Print)

Today's Date:_____

Name:_____

Street Address:_____

Phone:
(home):_____(cell):_____(work):_____

Occupation:_____Age:_____Email:_____

Date of Birth:_____

Person to contact in case of emergency:
Name:_____Phone:_____

Please circle any of the following that apply:

High Blood Pressure Heart Problems Post-Partum Neurological
Diabetes Joint Problems Seizures Respiratory
Liver Disease Fractures Cancer Hernia
Pregnant Recent Surgeries Asthma Scoliosis
Shortness of Breath Arthritis Chronic Illness Balance
Back Problems Allergies Osteoporosis

***If you circled any of the above, please explain:_____**
_____

How did you hear about us?_____

What are your fitness goals?_____

Are there any other things you would like to tell us about your health?_____

Current physical activity level and exercises:_____

Past experience with Pilates:_____

Are you under the care of a physician, chiropractor or physical therapist for a musculoskeletal problem?_____If so, please explain:_____