# New Client Health Profile

**Date:** _____

Name: _____ Birthdate: _____ Age: _____

Address: _____ City: _____ Zip: _____

Email: _____ Phone: (h) _____ (c) _____

**Medical History:**

Height: _____ Weight: _____

Primary Care Doctor: _____ Phone: (___) _____

Emergency Contact: _____ Phone: (___) _____

1). Are you currently under a doctor's care? _____ Yes _____ No

2). Is your doctor aware you are beginning a new exercise program? _____Yes _____ No

3). Are you currently taking any medications? ____ Yes _____ No If answered "yes", for what are you being treated?_____

_____

4). Have you had any injuries? _____ Yes _____No

Please describe. Include dates and treatment, if any. _____

_____

_____

5). Have you ever been hospitalized or had any surgeries? Please list dates and reason. _____

_____

_____

6). Do you have any of the following? Please elaborate on any items checked.

| | | | |
|---|---|---|---|
| _____Allergies | _____ Cancer | _____ Hip Replacement | _____ Stroke |
| _____ Alcoholism | _____Chest Pains | _____ Hypertension | _____ Thyroid |
| _____ Anemia | _____Diabetes | _____ Kidney Issues | _____ Other |
| _____ Anorexia | _____ Fusions- back,cervi cal | _____ Knee Replacement | |
| _____ Arthritis | _____ Heart Problems | _____ Low Blood Pressure | |
| _____ Auto Immune | _____ Hernias | _____ Lung Problems | |
| _____ Bulging Discs | _____ Hepatitis | _____Osteoporosis/penia | |
| _____ Bulimia | _____ High Blood Pressure | _____Pregnancy | |

_____

_____

_____

**Current Lifestyle and Exercise:**

7). Please check any of the following that apply to you.

_____ Do you consume alcohol? How many drinks per day/week do you consume?_____
_____Do you smoke? How long have you smoked? _____How many packs per week? _____
_____ Do you consume caffeine? Please list # of drinks per day/week. _____
_____ Do you take vitamins? If so, list kind and amount _____
_____ How many hours of sleep do you get per night? _____
_____ Do you drink water? How much? _____

8). Please describe your diet. _____
_____
_____

9). Describe your current exercise regime. Include how often and duration. _____
_____
_____
_____

10). What are your goals in beginning pilates? _____
_____
_____

11). What time/day is best for you? Are you interested in partnering with others? _____Y _____N

Early morning, 6-8 Mid-morning, 9-11 Lunch, 12-2 Late afternoon, 4:30 – 7:00

Monday Tuesday Wednesday Thursday Friday Saturday

**Occupation:**

12). What is your current occupation? _____

Does your occupation require long periods of sitting? ___. How many hours per day do you sit? _____

Does your occupation require you to travel? _____

Does your occupation cause you anxiety and mental stress/fatigue? If yes, is it low, moderate, high?

Any other information you feel is important to disclose regarding your health, lifestyle, and goals. _____
_____
_____

By signing on behalf of self or a minor Participant, signee agrees to release, hold harmless, and indemnify (including medical costs and attorney's fees) **Center Pointe Pilates** and its owners for any claims brought by participant or on behalf of the minor.

**Signature:** _____ **Date:** _____

**Parent/Guardian if under 18:** _____ **Date:** _____