Louise O'Rourke
CHARTERED PHYSIOTHERAPIST

PILATES HEALTH SCREENING FORM

Name: _____

Address:

_____

Tel Home: _____Mobile _____

Email address: _____

Occupation _____

GP Name: _____GP Contact No: _____

GP Address:_____

Emergency contact name and phone no: _____

	Please Circle	
Do you suffer from neck problems?	YES	NO
Do you have a bad back, lower back pain, herniated disk?	YES	NO
Have you ever had a broken bone or fracture	YES	NO
Do you have a history of arthritis?	YES	NO
Do you have history of stroke?	YES	NO
Do you have history of cardiac problems?	YES	NO
Are you currently on any medication?	YES	NO
Have you ever been told you have high blood pressure/low blood pressure?	YES	NO
Have you ever had treatment for a back problem, slipped disc, sciatica?	YES	NO
If so, who are you receiving treatment from?		
Are you suffering from any other medical problems that may affect your ability to exercise e.g. osteoporosis, arthritis?	YES	NO
Have you any additional Health information that may be relevant?	YES	NO

Goals: _____

Signed: _____ Date: _____