



pi-LALA-tes

Health Screening

Name _____

Birthdate ____/____/____ Gender _____

Have you Ever been treated by a Physician for:

- | | | |
|--|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chronic Fatigue Syndorome | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Orthopedic/Joint (shoulder/ elbow/ spine/ hip/ knee) Problems | | |
| <input type="checkbox"/> Anterior Cruciate Ligament Knee Injuries | | |
| <input type="checkbox"/> Facet Joint Syndrome | | |
| <input type="checkbox"/> Herniated or Bulging Disc | | |
| <input type="checkbox"/> Spondylolisthesis | | |
| <input type="checkbox"/> Stenosis | | |
| <input type="checkbox"/> Total Hip Replacement | | |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Peripheral Neuropathy | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Other _____ | | |

Are you pregnant? Yes No

Prior Deliveries: _____

Prior Surgeries: _____

Prior Injuries, Musculoskeletal and Neuromuscular Issues:

- | | | |
|--|---|---|
| <input type="checkbox"/> Adhesive Capsulitis (frozen shoulder) | <input type="checkbox"/> Carpal Tunnel Syndrome | |
| <input type="checkbox"/> Plantar Fascitis | <input type="checkbox"/> Rotator Cuff Impingement | <input type="checkbox"/> Thoracic Outlet Syndrome |
| <input type="checkbox"/> Other _____ | | |

Activity Level/ Exercise Frequency: _____

Prior Movement Experience? (dance, Feldenkrais, Pilates, Yoga, etc) _____
