Pilates / Yoga Assessment Questionnaire

Contact details

First Name:	
Family Name:	
Date of Birth:	
Contact Telephone Number:	
Email:	
Emergency contact name:	
Emergency contact number:	

YOUR INFORMATION WILL BE TREATED CONFIDENTIALLY.

Your medical history

Do you suffer or have you suffered from any of the following?
If yes to any, please provide brief details:

		Please circle / tick	
1.	a) High or low blood pressure? b) Any Medication?	Yes Yes	No No
2.	Heart problems?	Yes	No
3.	Epilepsy? If yes, have your seizures been stabilised via medication?	Yes	No
4.	Asthma or breathing problems?	Yes	No
5.	Have you been diagnosed with osteoporosis?	Yes	No
6.	Have you had any admissions to hospital or surgery in the last 5 years? If yes, please specify:	Yes	No
7.	Are there any physical issues (including problems with the neck, back, hips, knees, ankles, feet etc) and / or mental health conditions (including anxiety, depression and stress) that your instructor should be aware of or that you would like them to be aware of in treating you as a Pilates / Yoga client?	Yes	No

If you have answered yes to question 7 above please provide further information (including whether you are currently experiencing the problem, things that help, things that make the pain / problem worse or trigger it, any medications):

Please Note: If your health changes so that you subsequently answer yes to any of the above questions please inform your instructor.

What are your goals in relation to Pilates / Yoga classes?

I have read, understood and completed this questionnaire and all questions have been answered to the best of my knowledge:

Signed: Date:

I consent to this form and the information on it being filed securely whilst I am a Pilates / Yoga client and to being contacted regarding Pilates / Yoga information by the instructor:

Signed: Date :