



Health & Fitness Questionnaire

YES NO

Date: Are you currently a member of Energy Pilates Fitness Yoga?

Name: Address:

Birthdate: Email:

Phone: Occupation:

How did you hear about us?

Emergency Contact Name: Relationship:

Emergency Contact Phone # Alt. Phone:

Please answer the following questions:

YES NO

- 1. Has your doctor ever said that you have a heart condition and you should only do physical activity recommended by a doctor?
- 2. Do you feel pain in your chest when you do physical activity?
- 3. In the past month, have you had chest pain when you were not doing physical activity?
- 4. Do you lose your balance because of dizziness or do you ever lose consciousness?
- 5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?
- 6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
- 7. Do you know of any other reason why you should not do physical activity?

Present / Past History:

Have you had, or currently have any of the following: (Please **check all that apply**)

- | | | |
|--|--|--|
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Edema | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Injury to back or knees | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Heart attack | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Fainting or dizziness | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Known heart murmur |
| <input type="checkbox"/> Palpitations or tachycardia | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Recent operation | <input type="checkbox"/> Other |



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Family History:

Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions?

- Heart condition High blood pressure High cholesterol
 Diabetes Other major illness

Activity:

1. Date of your last physical examination performed by a physician?

2. On a typical day do you do a lot of: (check boxes)

- Sitting Standing Bending Lifting Repetitive Movements

3. Do you participate in a regular exercise program at this time? Yes No

If yes, describe:

4. Have you ever performed resistance training exercises in the past? Yes No

5. Do you have injuries (bone or muscle disabilities) that may interfere with exercising? Yes No

If yes, briefly describe:

6. Do you smoke? Yes No If yes, how much per day and at what age did you start?

8. In general how do you feel about your weight/body image?



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9. Do you follow or have you recently followed any specific dietary intake plan and in general how do you feel about your nutritional habits?

10. Are there any injuries or limitations that have not been discussed up to this point?

11. Any minor or major surgeries we should know about?

Waiver: I do hereby state that the above information is true and complete to the best of my knowledge and that I will hold harmless any teacher, trainer, or staff member of Energy Pilates Fitness Yoga for any liable for any mishaps or injuries (physical or otherwise) arising from my training. I acknowledge that my choice to participate in training sessions is my complete personal responsibility, and such participation is at my own risk. On behalf of myself and all others in legal relationship with me, I hereby release the above-mentioned and all affiliates, from any and all liability for any injury, either emotional or physical, which may occur to me while I am a client Energy Pilates Fitness Yoga as a result of using any information or instructions I receive from them or any affiliates. I declare that I have read, understood and agreed to the contents of this waiver in its entirety.

Signature: _____

Date: _____