PINECREST PILATES EVALUATION FORM

NAME_____ **DATE**_____

DOB_____ **HOME PHONE**_____

AGE_____ **WORK PHONE**_____

E-MAIL_____ **DOCTOR**_____

ADDRESS_____

EMERGENCY CONTACT_____

EMERGENCY CONTACT PHONE # _____

HAVE YOU EVER TAKEN PILATES BEFORE? _____

IF SO, WHERE AND WHAT TYPE? _____

ARE YOU CURRENTLY INVOLVED IN A STRENGTH TRAINING PROGRAM?_____

IF SO, WHAT FORM OF EXERCISE AND HOW OFTEN?_____

ARE YOU CURRENTLY ON A CARDIOVASCULAR EXERCISE PROGRAM?_____

IF SO, HOW OFTEN AND DURATION? _____

WHAT ARE YOUR MAIN REASONS FOR TAKING PILATES?

- **INCREASE FLEXIBILITY**
- **IMPROVE POSTURE / ALLIGNMENT**
- **INCORPORATE INTO ALREADY EXISTING WORKOUT PROGRAM**
- **STRENGTHEN BACK AND CORE MUSCLES**
- **REPLACE EXISTING WORKOUT**
- **BUILD BALANCED MUSCLES TO PREVENT INJURIES**
- **JUST WANT TO TRY IT**

WHAT IS YOUR CURRENT FLEXIBILITY/ STRETCHING ROUTINE?
___DAILY ___ONCE PER WEEK ___AFTER EXERCISE ONLY ___OCCASIONALLY

WHAT ARE YOUR CURRENT SLEEPING HABITS?
___8 HRS ___6 HRS ___LESS THAN 6 HRS

WHAT ARE YOUR CURRNT EATING HABITS?
___1-2 MEALS A DAY ___AT LEAST 3 MEALS A DAY ___3-5 MEALS A DAY

WHAT IS YOUR ULTIMATE GOAL IN PILATES? _____

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CIRCLE ONE

1. YES/NO	**HAS A PHYSICIAN EVER SAID YOU HAVE A HEART CONDITION AND YOU SHOULD ONLY DO PHYSICAL ACTIVITY RECOMMENDED BY A PHYSICIAN?**
2. YES/NO	**WHEN YOU DO PHYSICAL ACTIVITY, DO YOU FEEL PAIN IN YOUR CHEST?**
3. YES/NO	**WHEN NOT DOING PHYSICAL ACTIVITY, HAVE YOU HAD CHEST PAIN IN THE PAST MONTH?**
4. YES/NO	**DO YOU EVER LOSE CONSCIOUSNESS?**
5. YES/NO	**DO YOU LOSE YOUR BALANCE BECAUSE OF DIZZINESS?**
6. YES/NO	**IS A PHYSICIAN CURRENTLY PRESCRIBING MEDICATION FOR A HEART CONDITION?**
7. YES/NO	**IS A PHYSICIAN CURRENTLY PRESCRIBING MEDICATION FOR A BLOOD PRESSURE CONDITION?**
8. YES/NO	**DO YOU HAVE INSULIN DEPENDENT DIABETES?**
9. YES/NO	**ARE YOU 65 YEARS OF AGE OR OLDER?**
10.YES/NO	**HAVE YOU EVER BEEN IN A CAR ACCIDENT RESULTING IN TRAUMA TO THE SPINE?**
11.YES/NO	**DO YOU HAVE JOINT OR BONE PROBLEMS THAT MAY BE MADE WORSE BY CHANGE IN PHYSICAL ACTIVITY?**
12.YES/NO	**DOES OSTEOPOROSIS RUN IN YOUR FAMILY?**
13.YES NO	**DO YOU HAVE ANY LOWER BACK PAINS/PROBLEMS OR LIMITED RANGE OF MOTION?**
14.YES/NO	**DO YOU HAVE ANY NECK PAINS/PROBLEMS OR LIMITED RANGE OF MOTION?**
15.YES/NO	**DO YOU HAVE ANY OTHER REASON YOU SHOULD NOT EXERCISE OR INCREASE YOU PHYSICAL ACTIVITY?**
16.YES/NO	**HAVE YOU HAD ANY SURGERIES WITHIN THE PAST 3 YRS?**
17.YES/NO	**ARE YOU PREGNANT?**
18.YES/NO	**ARE YOU CURRENTLY BEING TREATED BY A CHIROPRACTOR?**
19.YES/NO	**ARE YOU CURRENTLY BEING TREATED BY A PHYSICAL THERAPIST?**
20.YES/NO	**ARE YOU CURRENTLY BEING TREATED BY AN ACUPUNCTURE PHYSICIAN?**

*PLEASE CHECK WITH YOUR PHYSICIAN BEFORE STARTING ANY EXERCISE PROGRAM