

# PILATES ON TAY



## Client Questionnaire

This form is designed to help us gather more information about yourself/individual clients. It is completely confidential and is not used as a diagnostic tool, but will help us to create a more specific programme for you. Please answer the questions as completely as possible. If you are in doubt about exercising, then please consult your GP before commencing with this exercise class.

*Please Use Block Capitals*

Name: \_\_\_\_\_ Telephone: (home) \_\_\_\_\_

Address: \_\_\_\_\_ (work) \_\_\_\_\_

\_\_\_\_\_ (mobile) \_\_\_\_\_

\_\_\_\_\_ Email: \_\_\_\_\_

Postcode: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Profession: \_\_\_\_\_ Recommended by (Please tick the relevant box)

Work Address: \_\_\_\_\_  Friend

\_\_\_\_\_  Health Practitioner

\_\_\_\_\_  Doctor

\_\_\_\_\_  Website

\_\_\_\_\_  Other - please specify

Emergency contact name and telephone:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Sports/Hobbies: \_\_\_\_\_

Does your work/sport/hobby involve any of the following? (Please tick)

	<u>Work</u>	<u>Sport</u>	<u>Hobby</u>
Sitting for long periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting heavy weights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other repetitive action	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please expand on this information if necessary: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you any joint problems or have any artificial joint/s? (Please tick appropriate box)

Yes  No

If yes, please specify \_\_\_\_\_

\_\_\_\_\_

Blood Pressure (Please tick appropriate box)

High                      Low                      Normal                      Don't Know

                                                                

Have you ever broken a bone? (Please tick appropriate box)

Yes  No

If yes, please specify \_\_\_\_\_

\_\_\_\_\_

May we keep a list of any prescribed medication you are taking? (Please tick appropriate box)

Yes  No

If yes, please specify \_\_\_\_\_

Have you had any major illness or operations? (Please tick appropriate box)

Yes  No

If yes, please specify \_\_\_\_\_

Have you had any operations or injuries within the last six months? (Please tick appropriate box)

Yes  No

If yes, please specify \_\_\_\_\_

Do you wear a pacemaker? (Please tick appropriate box)

Yes  No

If yes, please specify \_\_\_\_\_

Are you pregnant or have you had a baby in the last six months? (Please tick appropriate box)

Yes  No

If yes, please specify \_\_\_\_\_

Have you ever been given remedial exercise, such as physiotherapy? (Please tick appropriate box)

Yes  No

If yes, please specify \_\_\_\_\_

Are there any movements that cause you pain? (eg raising arms, bending forward or to the sides)

Yes  No

If yes, please specify \_\_\_\_\_

Is there any other reason, not yet mentioned, that should prevent you performing physical exercise?

Yes  No

If yes, please specify \_\_\_\_\_

Do you have any large scars? (Please tick appropriate box)

Yes  No

If yes, please specify \_\_\_\_\_

Do you suffer from any of the following? (Please tick appropriate box)

Asthma  Allergies  Heart Trouble  Arthritis   
Diabetes Type 1  Diabetes Type 2  Epilepsy  Osteoarthritis   
Osteoporosis  Migraine  Depression  Anxiety   
Difficulty in hearing  Difficulty in seeing

If you have answered yes to/ ticked any of the above, please expand on your information here:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Homeopathy  Acupuncture  Physiotherapy   
Osteopathy  Chiropractor  Nutritionist   
Masseur  Bowen technique  Reiki or other healing

Are you currently receiving any complementary/physical therapy? (Please tick as appropriate)

Other (Please state) \_\_\_\_\_

**Referral from (please state: Physiotherapist, Osteopath, GP or other)**

---

Notes provided: Yes/No

**If notes are not provided, we will/may seek your permission to liaise with your health professional in order to gather more information about your condition.**

Recommendation or guidelines from your medical/health practitioner:

---

---

---

---

Have you exercised in the past, or at present? (Please specify) \_\_\_\_\_

---

---

It is inadvisable to do Pilates between 6 and 14 weeks of pregnancy unless by special arrangement with your teacher. We will also require a note from your doctor. We will/can continue to teach you Pilates after the birth once the 6 week check has been performed by your doctor.

The very nature of Pilates requires 'hands on' guidance from your teacher. This medium of teaching is used as a professional means of guiding you, the client, correctly through exercises. If you would prefer to avoid this, please let your teacher know.

Please advise your teacher before commencing a class if, for any reason, your ability to exercise has changed.

Pilates' exercises are very safe but, as with all forms of physical exercise, if you have any problems it is prudent to consult your doctor before starting classes. (We can speak to your Doctor if necessary.)

The classes are NOT a substitute for medical treatment or counselling. If you have any doubts about the suitability of the exercises, you should refer back to your medical practitioner. If you have

declared a medical condition, we require written confirmation from your GP before you can undertake this Pilates class.

## Important Notice

**It is your responsibility to inform the teacher of any changes that may affect your exercise programme such as:**

- Your Doctor (or any other health practitioner) has, on health grounds, advised you against such exercise
- If you do not disclose important medical details or changes to your ability to exercise to your teacher

**It is also your responsibility to:**

- To observe instructions on safety or technique on performance or use of equipment
- Not to drink alcohol or take recreational drugs before a class
- Not to have a heavy meal less than two hours before you exercise

**At all times, you must maintain a responsibility of awareness for any other participant(s) in the studio to:**

- Avoid negligence of own person or that of another exercising in the studio

Any clients over 50 who have declared any condition on this form must get a GP's permission before exercising.

The undersigned indicates that he/she is financially responsible for payment of all Pilates' lessons.

I agree to give 48 hours' notice (Monday to Friday) for the cancellation of sessions. Should I fail to give the required notice, I agree to pay the fee for the missed visit. All prepaid sessions and classes are non-refundable. All prepaid sessions must be taken within 3 months of the payment date.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Please print name \_\_\_\_\_

## Teacher taking assessment

Signature \_\_\_\_\_

Date \_\_\_\_\_

Please print name \_\_\_\_\_