

Northshore Pilates

2609 Broadway, Evanston, IL 60201

847-425-1925

**Health History Form**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender male \_\_\_\_\_ female \_\_\_\_\_

Age \_\_\_\_\_\_\_\_\_ Birth date \_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your physician know that you are participating in an exercise/fitness program? \_\_\_\_\_

Date of last physical examination \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications?

no \_\_\_\_ yes \_\_\_\_ (Please list medications and reasons for usage below.)

Medication Reason for usage

Are you taking any vitamins or dietary supplements?

no \_\_\_\_ yes \_\_\_\_ (Please list supplements and reasons for usage below.)

Medication Reason for usage

Do you now, or have you had in the past: yes no

1. History of heart problems, chest pain or stroke? \_\_\_ \_\_\_
2. Increased blood pressure? \_\_\_ \_\_\_
3. Any chronic illness or condition? \_\_\_ \_\_\_
4. Do you ever get dizzy, lose your balance or lose consciousness? \_\_\_ \_\_\_
5. Difficulty with physical exercise? \_\_\_ \_\_\_
6. Advice from physician not to exercise? \_\_\_ \_\_\_
7. Recent surgery (last 12 months)? \_\_\_ \_\_\_
8. Pregnancy (now or within last 3 months)? \_\_\_ \_\_\_
9. History of breathing or lung problems? \_\_\_ \_\_\_
10. Swollen, stiff, or painful joints? \_\_\_ \_\_\_
11. Foot problems? \_\_\_ \_\_\_
12. Back problems? \_\_\_ \_\_\_
13. Any significant vision or hearing problems? \_\_\_ \_\_\_
14. Diabetes or thyroid condition? \_\_\_ \_\_\_
15. Cigarette smoking habit? \_\_\_ \_\_\_
16. Do you ever drink alcoholic beverages? \_\_\_ \_\_\_
17. Increased blood cholesterol? \_\_\_ \_\_\_
18. History of heart problems in immediate family? \_\_\_ \_\_\_
19. Hernia or a condition that may be aggravated by lifting weights? \_\_\_ \_\_\_
20. Do you have asthma?

Please explain any yes answers below:

Do you have any other medical conditions or problems not previously mentioned?

If so, please explain.

**Family History Form**

**Father**

Current age \_\_\_\_\_\_\_\_\_\_\_

Father’s general health is: excellent \_\_\_ good \_\_\_ fair \_\_\_ poor \_\_\_

Reason for fair/poor health is? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mother**

Current age \_\_\_\_\_\_\_\_\_\_\_

Mother’s general health is: excellent \_\_\_ good \_\_\_ fair \_\_\_ poor \_\_\_

Reason for fair/poor health is? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Siblings**

Number of brothers \_\_\_\_\_\_ Number of sisters \_\_\_\_\_\_ Age range \_\_\_\_\_\_\_\_\_\_\_\_

Any health problems? Please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Have any of your BLOOD relatives had**: yes no

1. Heart attack under age 50? \_\_\_ \_\_\_
2. Stroke under age 50? \_\_\_ \_\_\_
3. High blood pressure? \_\_\_ \_\_\_
4. Elevated cholesterol? \_\_\_ \_\_\_
5. Diabetes? \_\_\_ \_\_\_
6. Asthma or hay fever? \_\_\_ \_\_\_
7. Heart operations? \_\_\_ \_\_\_
8. Obesity? \_\_\_ \_\_\_
9. Leukemia or cancer under age 60? \_\_\_ \_\_\_

**Comments**

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

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

**Goals**

Cardio-respiratory endurance, Muscular Strength & Endurance, Flexibility,

Body Composition & Nutrition.

Long term goals:

1.

2.

3.

Short term objectives:

1.

2.

3.

**Terms of Training**

* I understand that all sessions must be pre-paid.
* I am aware that it is my responsibility to attend all scheduled appointments. **If I need to cancel or reschedule, I must give 24 hour notice or I will be billed for the missed session.**
* **I agree to use my 10 sessions within a six (6) month time period from the purchase date**. I understand that after six (6) months from the purchase date, my sessions will expire and that I will lose any remaining sessions. Owner approval is required for any exceptions or extensions to your package past the six (6) month term.
* I understand that my regular session time may change if I am unable to attend beyond a two (2) week time period. We cannot hold "spots" beyond two (2) missed sessions or classes.
* I understand that all training sessions that I purchase are non- refundable.
* I understand the Pilates training price structure and agree to all the aforementioned policies.

**Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_**

At Northshore Pilates, we strongly recommend that all participants in our exercise programs

consult their physician prior to participation.

I acknowledge, to the best of my ability, that I am in good health and have no known medical

problems that would restrict my ability to participate in this exercise program.

**Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_**