Pre-exercise screening and consent form

Name:_____

Mobile:_____

Email:_____

DOB:_____(optional)

Emergency contact name and number:_____

Current injuries/restrictions:_____

Previous injuries:_____

Medications that may affect your ability to exercise safely:_____

_____

Medical Practitioner:_____ Phone:_____

Have you ever had any of the following conditions?

☐ Stroke
☐ Blood pressure
☐ Asthma
☐ Epilepsy
☐ Arthritis
☐ Recurring headaches
☐ Migraine

Do you suffer pain or restricted movement in any of the following?

☐ Neck:_____ ☐ Hips:_____
☐ Shoulders:_____ ☐ Knees:_____
☐ Back:_____ ☐ Ankles:_____
☐ Other:_____

Are you pregnant: ☐ Yes ☐ No If yes, when are you due?_____

Current exercise:_____

Frequency:_____Goals:_____

I agree that the information I have provided is accurate. I have read and understood all wording printed in this document and take full responsibility for my actions at all times throughout my Pilates sessions. I am reasonably fit, healthy and able to participate in mat classes and will advise Pilates Tasmania should my medical or health conditions change.

Signed:_____**Date:**_____