Remedy
Pilates & Physiotherapy

PILATES MEDICAL SCREENING FORM		All information will be kept in strict confidence
Name:		Age: Date of Birth:
Permanent Address:		Phone No.:
Email:		Occupation:
How did you hear about us (please circle)		GP: Surgeon: Physio: Other Therapist:
Website Facebook Twitter Instagram	GP Google By a friend Passing by	
Person to contact in case of emergency: Name:		Phone:

Tick Relevant boxes:

Diabetes		Chronic Illness		Depression	
Epilepsy		Respiratory		Smoker	
Arthritis		High/Low Blood Pressure		Pregnancies	
Heart Problems		Neurological disorder		Children	
High Cholesterol		Cancer		Pelvic Floor Problems	
Surgery		Osteopenia/Osteoporosis		Musculoskeletal complaints	

Please give details of the above and any treatment received:

Medication(s):

Do you have any pain or discomfort at present?

Where? For how long?

Reason for visit/What are your goals?

Sports/Hobbies:

Have you ever done Pilates before? (please circle) Y/N Mat Pilates / Reformer Pilates

Do you exercise at present? Y/N. ______ times per week, _______ min per session (average)

Intensity (please circle) : Low Moderate Vigorous

I declare that to the best of my knowledge the information given above is correct and I am not aware of any reason why I should refrain from exercise. I, herby consent to assessment and treatment by the Remedy Therapy Team.

Signed: ______________________ **Date:** ___________ **Please turn over→**