HEALTH SCREENING FORM

Name: _____ Address:_____

City: _____ Zip Code: _____

E-Mail: _____ Phone: _____

Birthday: (M) _____ (D) _____ (Y) _____ Age: _____

How did you hear about us?

___ Internet ___ Groupon ___ Amazon/LivingSocial ___ ClassPass

___ Walk-By ___ Friend/Family ___ Another Client (_____)

Have you ever been treated by a physician for the following (please check)?

___ Heart disease
___ High blood pressure
___ Gastric reflux
___ Glaucoma
___ Orthopedic/joint (shoulder/elbow/spine/hip/knee) problems
___ Osteoporosis
___ Arthritis
___ Peripheral neuropathy (numbness/tingling/diminished sensation)

Are you pregnant? Yes No Prior deliveries? _____

Prior surgeries? Please list. _____

Prior injuries? Please list. _____

Current injuries? Please list. _____

_____

Activity level/exercise frequency?

_____

_____

Prior movement experience? (Dance, Pilates, yoga, etc.)

_____ _____

_____

Emergency Contact: _____

Relationship: _____

Phone: _____