The Pilates Wellness Center

Leaner, Longer, Firmer, Stronger

Welcome to The Pilates Wellness Center.

We take a very thorough and comprehensive approach towards attaining your goals. We believe superb well-being is achieved when each body system is functioning at its optimum, and health is not the mere absence of pain or symptoms. Our Goal is to guide you into a continuous state of superb well-being for years to come. In order for us to serve you better, please fill out our Health Questionnaire Form to the best of your ability.

Please print clearly. All information is strictly confidential.

First Name: _____ Last: _____ ❑ M ❑ F

Local Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Email: _____

Birth Date: _____/_____/____ Age: _____ Martial Status: ❑ S ❑ M ❑ D ❑ W

Emergency Contact: _____ Relationship: _____ Phone: _____

Who can we thank for referring you? _____ How did you hear about us? _____

Please tell us about your Pilates experience: ❑ Professional Equipment ❑ Mat ❑ Gym Pilates ❑ Video ❑ None

How long have you done Pilates?_____ How often were you doing pilates/week?_____

What did you enjoy about Pilates? _____

What was challenging about Pilates? _____

Please tell us what your Pilates Fitness and/or Pilates Rehabilitation goals are:

Leaner: _____	Flexibility:_____	Improve Posture: _____	Increase Mind/Body Awareness: _____
Longer:_____	Increase Tone: _____	Decrease Pain: _____	Improve Range of Motion: _____
Firmer: _____	Increase Energy: _____	Improve Health: _____	Improve Sports Performance: _____
Stronger: _____	Feel Better: _____	Improve Balance: _____	Other: _____

Please tell us about your Chiropractic experience: ❑ Wellness Care ❑ Acute Care ❑ Car Accident ❑ Other ❑ None

How long have you received Chiropractic Care?_____ How often?_____

Why did you receive Chiropractic Care? _____

What did you enjoy about Chiropractic? _____

What was challenging about Chiropractic? _____

Please tell us what your Chiropractic Wellness goals are:

Improve Posture: _____	Improve Range of Motion: _____	Improve Memory: _____
Decrease Pain: _____	Improve Flexibility: _____	Improve Organ Health: _____
Improve Balance: _____	Improve Stability: _____	Decrease Fight/Flight: _____
Feel Better: _____	Improve Postural Endurance: _____	Other: _____

Please tell us what musculoskeletal issues you are experiencing:

Issue #1: _____ When did it start?_____/_____/_____

How did it start? _____
What makes it better?_____
What makes it worse?_____
Is the pain? ❑ Dull ❑ Achy ❑ Throbbing ❑ Numb ❑ Tingling ❑ Sharp ❑ Shooting ❑ Burning ❑ Spasm
Rate your pain: a) At its worse use "x" I——————I——————I
b) What it usually is "o" 0 5 10
Is the pain? ❑ Constant ❑ Comes and goes ❑ Only with rest ❑ Only with movement
Does the pain radiate? ❑ Yes or ❑ No

What treatments have already received for this issue: ❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic
What were the results? _____

Issue #2: _____ When did it start?_____/_____/_____

How did it start? _____
What makes it better?_____
What makes it worse?_____
Is the pain? ❑ Dull ❑ Achy ❑ Throbbing ❑ Numb ❑ Tingling ❑ Sharp ❑ Shooting ❑ Burning ❑ Spasm
Rate your pain: a) At its worse use "x" I——————I——————I
b) What it usually is "o" 0 5 10
Is the pain? ❑ Constant ❑ Comes and goes ❑ Only with rest ❑ Only with movement
Does the pain radiate? ❑ Yes or ❑ No

What treatments have already received for this issue: ❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic
What were the results? _____

What you do for physical activity?
_____

How intense?	How often?
❑ Light	❑ Once a week
❑ Moderate	❑ 2-3/week
❑ Heavy	❑ Daily

What is your work activity like?
Number of hours in each activity?

❑ Sitting	_____ # of hr
❑ Standing	_____ # of hr
❑ Light Labor	_____ # of hr
❑ Heavy Labor	_____ # of hr

Please tell us about (if not stated above):

	Date	Description
Falls/Fractures:	_____	_____
Car Accidents:	_____	_____
Head Injuries:	_____	_____
Surgeries:	_____	_____
Hospitalization:	_____	_____

Please check any diseases/conditions you have ever had:

❑ Autoimmune	❑ Allergies	❑ Anemia	❑ Appendicitis	❑ Arthritis	❑ Asthma
❑ Bleeding Disorders	❑ Breast Lumps	❑ Bronchitis	❑ Cancer	❑ Diabetes	❑ Dizziness
❑ Digestive Issues	❑ Emphysema	❑ Epilepsy	❑ Fatigue	❑ Goiter	❑ Gout
❑ Heart Disease	❑ Hepatitis	❑ Hernia	❑ Herniated Disc	❑ Herpes	❑ High Cholesterol
❑ High Blood Pressure	❑ Hypoglycemia	❑ Kidney Disease	❑ Liver Disease	❑ Migraines	❑ Memory Issues
❑ Miscarriage	❑ Mononucleosis	❑ MS	❑ Osteoporosis	❑ Pacemaker	❑ Parkinsons
❑ Pinched Nerve	❑ Pneumonia	❑ Prostate Issues	❑ RA	❑ Sinus Issues	❑ Stiffness (joints)
❑ Stroke	❑ Thyroid Issues	❑ Tuberculosis	❑ Tumors/Growths	❑ Ulcers	❑ Vaginal Infections

Is there a family history of any diseases or conditions? _____

Please list all Medications you are taking:

	Dose	Frequency
❑ Anxiety/Depression	_____	_____
❑ ADD/ADHD	_____	_____
❑ Blood Pressure	_____	_____
❑ Cholesterol	_____	_____
❑ Diabetes	_____	_____
❑ GERD	_____	_____
❑ Joint Pain	_____	_____
❑ Migraine/Headache	_____	_____
❑ Muscle Relaxers	_____	_____
❑ Pain Narcotics	_____	_____
❑ Sleeping Pills	_____	_____
❑ _____	_____	_____
❑ _____	_____	_____
❑ _____	_____	_____

Please list all Supplements you are taking:

	Dose	Frequency
❑ Multi - Vitamin	_____	_____
❑ Multi - Mineral	_____	_____
❑ Fish Oils/Omega 3	_____	_____
❑ Omega 6	_____	_____
❑ Probiotics	_____	_____
❑ Vitamin D3	_____	_____
❑ Digestive Aids	_____	_____
❑ Bone Building	_____	_____
❑ Adrenal/Immune	_____	_____
❑ Allergies	_____	_____
❑ _____	_____	_____
❑ _____	_____	_____
❑ _____	_____	_____
❑ _____	_____	_____

Please tell us about your Functional Medicine experience:

Have you had a Medical Nutrition & Lifestyle Consultation before? ❑ No ❑ Yes, done by ❑ MD ❑ DABCN ❑ Nutritionist
Have you had a Comprehensive Functional Blood Evaluation done before? ❑ No ❑ Yes When: _____
Do you have food allergies? ❑ No ❑ Yes ❑ Unsure Food allergy testing? ❑ No ❑ Yes When: _____
Do you do metabolic cleanses? ❑ No ❑ Yes How often: _____

How much do you consume per day?

❑ Water _____	❑ Fruits _____	❑ Dairy _____	❑ Smoking - Packs/Day _____
❑ Tea _____	❑ Veggies _____	❑ Salt _____	❑ Alcohol - Drinks/Week _____
❑ Soda _____	❑ Protein _____	❑ Fats _____	❑ Coffee/Caffeine Drinks - Cups/Day_____
❑ Juice _____	❑ Fish _____	❑ Sugar _____	❑ High Stress Level - Reason _____

Please tell us what your Health Goals are:

❑ Leaner	❑ Increase Balance	❑ Decrease Pain	❑ Increase Energy	❑ Increase Sex Drive	❑ Decrease Fatigue
❑ Longer	❑ Increase Flexibility	❑ Decrease Symptoms	❑ Improve Sleep	❑ Improve Digestion	❑ Lower Cravings
❑ Firmer	❑ Increase Strength	❑ Eliminate Medications	❑ Improve Stamina	❑ Improve Posture	❑ Strengthen Bones
❑ Stronger	❑ Increase Endurance	❑ Feel Better	❑ Mental Clarity	❑ Balance Hormones	❑ Increase Immunity

What is your commitment towards:

OBTAINING optimal health and wellness? 10% --- 20% --- 30% --- 40% --- 50% --- 60% --- 70% --- 80% --- 90% --- 100%

MAINTAINING optimal health and wellness? 10% --- 20% --- 30% --- 40% --- 50% --- 60% --- 70% --- 80% --- 90% --- 100%

I, the undersigned, do hereby certify that I have understood and completed the above information and know it to be truthful and accurate to the best of my knowledge.

Print Name: _____ Date: _____

Signature: _____