practice
pilates • yoga • nutrition • for life

5575 Far Hills Ave
Dayton, OH 45429
(937) 432-9399
www.practice-center.com

Information Questionnaire

In order to customize your program to best suit your needs at Practice, please answer all of the following questions as truthfully as possible.

Name:_____Today's Date:_____

Male/Female (circle one) Date of Birth:_____

Address:_____

_____

Home Phone:_____Work Phone:_____Mobile Phone:_____

e-mail address: _____

In case of emergency, please contact:_____Phone:_____

Primary Care Physician:_____Phone:_____

How did you learn about the Studio? (circle one)

Google Internet CitySearch Flyer Referral Other

Saw Building Sign

If you were referred to the Studio, who referred you? _____

PERSONAL HISTORY

Please mark a check next to all of the questions you would answer yes to.

Do you have any personal history of heart disease?

Any personal history of metabolic disease (thyroid, renal, liver)?

Have you had diabetes for less than 15 years?

Have you had diabetes for more than 15 years?

Have you experienced pain or discomfort in your chest apparently due to blood flow deficiency?

Any unaccustomed shortness of breath (perhaps during light exercise)?

Have you had any problems with dizziness or fainting?

Do you have difficulty breathing while standing or sudden breathing problems at night?

Do you suffer from ankle edema (swelling of the ankles)?

Have you experienced a rapid throbbing or fluttering of the heart?

Have you experienced severe pain in leg muscles during walking?

Do you have a known heart murmur?

Do you have any family history of cardiac or pulmonary disease prior to age 55?

Have you been assessed as hypertensive on at least 2 occasions?

Has your serum cholesterol been measured at greater than 140?

Are you a cigarette smoker?

Would you characterize your lifestyle as sedentary?

Do you currently have plantar's warts? (warts on the soles of the feet)

Have you ever had a bad sprain? Where?

_____

Have you ever broken a bone? Which bone?

_____

Have you ever been hospitalized?

_____

Do you have any children?_____ If so, how many?_____ Did you need a C-Section?_____

FAMILY HISTORY

The prior section pertained only to you, this section please place a check next to any that apply. Have your mother, father, or siblings suffered from:

	Heart attack or surgery prior to age 55		High cholesterol
	Stroke prior to age 50		Diabetes
	Congenital heart disease or left ventricular hypertrophy		Obesity
	Hypertension		Asthma
	Osteoporosis		Leukemia

MEDICATIONS

Please select any medications you are currently using.

	Diuretics		Other Cardiovascular
	Beta Blockers		NSAIDS/Anti-inflammatories (Motrin, Advil)
	Vasodilators		Cholesterol
	Alpha Blockers		Diabetes/Insulin
	Calcium Channel Blockers		Other Drugs (record below)

Please list the specific medications that you currently take:

_____

_____

Please indicate any other medical conditions or activity restrictions that you may have. It is important that this information be as accurate and complete as possible.

_____

_____

Please indicate if any of this information is critical to understanding your readiness for exercise? Are there any other restrictions on activity that we should know about?

_____

_____

Thank you for taking time to complete this questionnaire!!