Health Assessment

Knowing more about you, your wellness goals, and your health history is VITAL to help guide you in to the right Studio 54 Pilates & More programs. Please take a few minutes to thoughtfully complete our Health Survey and Assessment Form. Help us get to know you, and your body better, so we can get your Studio 54 Training Program off to a GREAT start!

After submitting your completed Health Survey, A Studio 54 Health Specialist will contact you to answer any additional question, and help get you started. We look forward to helping you enhance your Mind-Body JOJO to look good, feel great and enjoy a healthy and active life!

CONTACT INFORMATION

Name (First, MI, Last):

Address:

City/State/Zip:

Cell Phone: Email:

Preferred Method of Communication (newsletters will be distributed via email): Call ☐ Text ☐ Email ☐

Age: Sex: Male ☐ Female ☐ Other:

EMERGENCY CONTACT

Name (First, Last):

Phone: Relationship to you:

Physician Name:

Physician Address:

Physician City/State/Zip:

Office Phone:

WHY STUDIO 54 PILATES & MORE?

What is your #1 reason for getting started at Studio 54 Pilates & More

How did you find us? Client Referral ☐ Referred By:

Drive By ☐ Online Search ☐ Facebook ☐ Postcard ☐ Other ☐

WEST: 9099 W Central, Wichita (316) 265-9700 | EAST: 214 S Rock Rd, Wichita (316) 425-5554
Amie@Highway54Pilates.com | Highway54Pliates.com

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WELLNESS GOALS

What are your top 3 Health and Wellness Goals?

1.
2.
3.

What is your current plan for reaching those goals?

How will you know that you are making progress to achieve your goals?

CURRENT FITNESS PROGRAM

Do you exercise regularly 3+ times per week? Yes ☐ No ☐

Rate your current level of conditioning in the following areas:

Cardiovascular Conditioning: Low ☐ Moderate ☐ High ☐

Muscle Strength: Weak ☐ Average ☐ Strong ☐

Flexibility: Stiff ☐ Average Flexibility ☐ Flexible ☐

Describe your current weekly workout routine:

Ideally, how many days would you like to do Pilates or other Studio 54 workouts?

1 Day/week ☐ 2 Days/week ☐ 3-4 Days/week ☐ 5 Or more days/week ☐

Rate your level of experience with the following modalities:

Pilates: No experience ☐ Matwork ☐ Equipment ☐

I consider my Pilates skills to be: Beginner ☐ Intermediate ☐ Advanced ☐

Gyrotonics® & Gyrokinesis®: No experience ☐ Gyrotonics ☐ Gyrokinesis ☐

I consider my Gyro skills to be: Beginner ☐ Intermediate ☐ Advanced ☐

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HEALTH HISTORY

Are you taking any percription or over the counter pain medications? Yes ☐ No ☐

If yes, which ones?

Are you taking any anti-inflammatory medications? Yes ☐ No ☐

If yes, which ones?

Now, or in the past, have you taken steroids or had cortisone injections? Yes ☐ No ☐

Please explain:

Briefly note any pains, problems and any musculoskeletal injuries (recent or past). Include if they are front or back/left or right. Please specify if any of these are chronic issues (if they regularly limit or affect your ability to enjoy exercise and normaly daily life activities):

Head		Upper Back	
Neck		Mid Bck	
Shoulders		Lower Back	
Chest		SI/Pelvis	
Ribs		Hips	
Abdomen		Legs	
Arms		Knees	
Elbows		Ankles	
Wrist/Hands		Feet	
Other/More			

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MEDICAL CONDITIONS

Yes	No	
☐	☐	Have you ever been diagnosed with heart trouble?
☐	☐	Have you ever taken medication for your heart?
☐	☐	Do you have high blood pressure (Hypertension)?
☐	☐	Did either of your parents die of a heart attack/stroke before the age of 50?
☐	☐	Did your mother, father or siblings have diabetes?
☐	☐	Do you have diabetes?
☐	☐	Do you take medication to lower your blood cholesterol?
☐	☐	Do you have arthritis, rheumatism or gout?
☐	☐	Have you been diagnosed with osteoperosis?
☐	☐	Do you have osteopenia
☐	☐	Do you smoke?
☐	☐	Do you have any pulmonary (lung) conditions?
☐	☐	Do you have a hernia?
☐	☐	Have you had a joint replaced?
☐	☐	Do you have scoliosis?
☐	☐	Do you have Glaucoma or other eye problems?
☐	☐	According to your physician are you 20 or more pounds overweight?
☐	☐	Are you pregnant?
☐	☐	Do you have any other medical conditions that need to be taken into consideration for exercise?

Notes:

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MEDICAL CONDITIONS

Please list any surgeries, serious injureis, broken bones and or accients (list the event and the year):

OSTEOPOROSIS SCREENING

Yes	No	
☐	☐	Do you have a small, thin frame?
☐	☐	Do you have a family history of osteoporosis?
☐	☐	Are you a postmenopausal woman?
☐	☐	Have you had early or surgically induced menopause?
☐	☐	Have you been taking excessive thyroid medication or high doses of cortisone-like drugs?
☐	☐	Is your diet low in diary products, and other sources of calcium?
☐	☐	Are you physically inactive?
☐	☐	Do you smoke cigarettes or drink alcohol in excess?

The more YES responses, the greater your risk for developing osteoporosis. Please consult with your physician and get a dexa-scan for bone-density screening to appropritately monitory your bone health.

Please note: For your safe participation in an exercise program, if you are pregnant, or if you have any pre-ex-isitng conditions which may be affected by exercise, you may be asked to consult with your physician to obtain written authorization and approval prior to participation. If you have any concerns about your health status and starting an exercise program, please see your Physician and ask for a signed letter of authorization clearly stating any known limitations or restrictions, as well as approval to exercise, and bring this withyou to your first scheduled appointment.

We look forward to helping you enhance your vitality and improve your Health and Fitness!

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