KATE CUNNINGHAM STUDIO Pilates

Physical Activity Readiness Questionnaire (PARQ)

The information requested on this form is used solely to provide you with the safest movement instruction. It may be passed onto another exercise or Pilates trainer in the rare event that a different instructor covers your class. Please fill out this form and sign the statement at the bottom to confirm all the information given is true & accurate to your knowledge. If you have any questions, please feel free to ask.

Name:_____ Gender:_____ Age:_____

Phone number: _____Email: _____

Emergency contact & phone number:_____

Hobbies/Recreational Activities and Frequency:_____

_____

Previous Experience with Pilates:_____

General Health (circle): Excellent Good Fair Poor

Personal Fitness Goals:_____

_____

Are You Currently Experiencing Any Physical Problems? If So, Please Explain:_____

_____

Previous Injuries:_____

Previous Surgeries:_____

1. Are you currently receiving professional health care services related to your mobility (i.e. Chiropractic, Massage Therapy, Osteopathy, Physical Therapy, etc...please circle):_____ Yes No
2. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by your doctor?_____ Yes No

3. Do you feel pain in your chest when you do physical activity?_____ Yes No

4. In the past month, have you had chest pain when you were not doing physical activity?_____ Yes No

5. Do you lose your balance because of dizziness or do you ever lose consciousness?_____ Yes No

6. Do you have a bone or joint problem (i.e. back, knee, hip, shoulder) that could be made worse by a change in your physical activity?_____ Yes No

7. Is your doctor currently prescribing medicine for your blood pressure or a heart condition?_____ Yes No

8. Do you know of any other reason why you should not do physical activity?_____ Yes No

9. Are you currently or have you previously been diagnosed with any of the following? (please tick):

Arthritis /Osteoarthritis		Numbness or Weakness	
Back / Neck Pain		Osteopenia	
Bowel / Bladder Changes		Osteoporosis	
Cancer		Sacroiliac Joint Dysfunction	
Circulatory / Heart / Metabolic Disease		Seizure Disorder	
Diabetes		Shoulder Impingement	
Dizziness / Fainting Disorder		Spondylolisthesis	
Glaucoma		Stenosis	
Heart Attack		Stroke	
High or Low Blood Pressure (circle)		Symphysis Pubis Dysfunction (SPD)	
Herniated Disc		Thyroid Disorder	
Hypoglycemia / Hyperglycemia		Pregnancy (currently)	

10. Are you currently taking any medication that could affect your balance, coordination, focus, ability to operate machinery or to understand / follow instruction? Yes No

11. Do you know of any reason, medical or otherwise, which may stop you from participating in Pilates training? If yes please provide more information Yes No

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If you are 'inactive' and / or answer 'Yes' to any of the above...

it is recommended that you consult your GP before proceeding. Tell your GP what question(s) you answered 'yes' to, or present this form and seek advice from your doctor as to your suitability for;

- unrestricted physical activity starting off easily and progressing gradually
- restricted or supervised activity to meet your specific needs, at least on initial basis

If medical clearance is required, I confirm that I have sought clearance from a medical practitioner, who has given me permission to attend Pilates Yes Not applicable

DECLARATION: I, THE UNDERSIGNED, DO HEREBY CERTIFY THAT I HAVE COMPLETED THIS INFORMATION AND KNOW IT TO BE TRUTHFUL AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Name (print):_____

Signature:_____ Date:_____