**DIAGNOSTIC HEALTH QUESTIONNAIRE**

Information provided in this form is confidential. Providing it is not obligatory so you might decide not to answer some of the following questions. However please note, that this knowledge helps the therapist to understand your body condition, motivation, needs as well as barriers and limitations and makes the training sessions more effective.

Filling in declaration and accepting rules of cooperation (from the last pages) is obligatory to start classes.

Date: …………………………………….

Name: ……………………………………………………………………………………………………………………………………………………

Telephone: ……………………………………………………………………………………………………………………………………………..

Date of birth: ……………………………………. Weight: …………………………… Height: ……………….

**PART 1: MEDICAL HISTORY & LIFESTYLE**

Profession: ………………………………………………………………………… Working hours per week : …………

Tick if you spend more than 25% of your day time for:

* sitting at the desk
* standing
* walking
* driving
* carrying heavy objects

How do you find your work?

* stressful
* active
* sedentary

Do you exercise regularly? ............................................................................................................................

Are you under the care of any doctor? ............................................................................................................................................................

**Underline correct answer next to the following questions. If necessary please specify your answer.**

Do you have heart issues ?.........…………........................................................................................ YES / NO

Have you ever felt pain in your chest while exercising?..................................................………….. YES / NO

Is your blood pressure normal? Too high? Too low? ……............................................................ YES / NO

Have you ever had a balance issue, a dizziness or have you ever fainted? …………………............ YES / NO

Do you suffer from motion sickness, claustrophobia or fear of heights?..................................... YES / NO

Do you suffer from migraines?……………….………………………………………………………………………………. YES / NO

Do you often have abdominal pain? .…………………………………………………………………………………….. YES / NO

Do you feel stiffness or tingling while exercising or staying still?................................................. YES / NO

Do you often have muscle cramps in your limbs? How often?............……………………………………. YES / NO

Do you feel any pain in your muscles or joints?...................………………………………….…………………. YES / NO

Do you feel any pain in your back?................................................................................................ YES / NO

Have you ever had any accident, injury, dangerous fall, twist, break, burn? …………………………… YES / NO

Have you had any laser treatments, podiatry, dental or other invasive procedures or surgeries or long-term injection therapies?………………………………………………………………………………….. …………………… YES / NO

Do you have any scars?.…………………………………………………………………………………………………………… YES / NO

Do you have any tattoo?…………………………………………………………………………..……………………………… YES / NO

Do you think you sleep long enough? …..………………………………………………………………………..…….… YES / NO

What time do you usually go to sleep?......................……………………………………………………………… ………………

In what position do you usually sleep? Which position is most comfortable for you?…………………………………

When you wake up you feel: rested / tired / in pain / face tension………………………………………………….…………

Do you smoke or have you smoked cigarettes?............................................................................ YES / NO

Do you take time to relax?............................................................................................................ YES / NO

Do you drink more alcohol than approximately one glass of wine per week?...…………….…………… YES / NO

Do you frequently feel stressed out?............................................................................................. YES / NO

Do you feel that you are a strong person?.................................................................................... YES / NO

Do you have or have you had any emotional trauma?.................................................................. YES / NO

Do you frequently feel tension in your jaw or do you have malocclusion?................…………….…… YES / NO

Do you have a visual impairment?……………………………………………………………………………………………. YES / NO

Do you feel hypersensitive to light?.............................................................................................. YES / NO

Do you have any allergy or intolerance?....................…………………………………………………….………… YES / NO

Do you frequently choke?....................…………..…….…………………………………………………….…………… YES / NO

Do you often bump into or trip over something?........................................................................ YES / NO

Do you take any medications on a regular basis?........................................................................ YES / NO

Do you or did you frequently take antibiotics? ............................................................................ YES / NO

What antibiotics? Do you check their side effects?……………………………………………..………………….. YES / NO

When was the last time you had a general blood test?……………….…………………………………………………….

Are you right-handed or left-handed? …………………….……………………………………………………………………….. R / L

**Concern only women:**

Are you or have you ever been pregnant? …………………….…………………………………………………………. YES / NO

Have you ever delivered a baby?………………………………………………………………………………………………. YES / NO

Is your menstruation regular?.............………………………………………….………………………………..…….… YES / NO

**Have you been treated for any of the following conditions (please tick as appropriate):**

anemia, asthma, bronchitis, cancer, HIV/AIDS, diabetes, epilepsy, depression, rheumatism, obesity or other eating disorders (e.g. bulimia, anorexia), ischemic stroke, hemorrhagic stroke, hemophilia, heart attack, discopathy, osteoporosis, multiple sclerosis, muscular dystrophy, gastric ulcer, intestinal diseases, urolithiasis, urinary incontinence

**Do you have other diagnosed illness?** ..………………………….……………………………………………………………………

**Do you have other locomotor system malfunction?** ......……………………………………………………………………

Do you know about any contraindication to physical exercise or other body limitation that might be dangerous for you while exercising?…………………………………………………………………………..………………….……………………………………………………………..….

**Provide precise answers next to the questions:**

How many drinks with caffeine do you drink per day? (i.e. coffee, Coca-cola) ……..…………………………………

How much water do you drink per day? ..…….…………………………….…………………………….…………………………....

How much fruits and vegetables do you eat per day? ..…………………………….…………………………….……………….

How many times per day do you eat sweets or drink sweet drinks? ...……………………….……………………………

How many times per week do you eat fried food? ………….………………….……………………….………………………….

Do you need to add a lot of salt to your meals? ................……….……………….…………………………………………….

What time do you usually eat the biggest meal? ……………..……………….……………………….…………………………..

**PART 2: GOALS**

What made you decide to take Pilates classes?.........................……………………………………………………………..

What would you like to focus on?

* body posture
* strength
* flexibility
* elimination of pain
* stress reduction and body relaxation
* other …………………………………………………………………………………………………………………………………...…….

What are the three most important goals you would like to achieve by attending Pilates classes?

1. …………………………………………………………………………………………………….…………………………………………....……....

2. …………………………………………………………………………………………………….………………………………………………….....

3. ……...……..…………………………………………………………………………………………………….………………………………………

Do you feel any barriers to practicing physical activity? Please list them below.

…………………………………………………………………………………………………….…………………………………………...……………….

Do you think these barriers or limitations could be reduced or overcome?

…………………………………………………………………………………………………….……………………………………………...……….……

What day / time is most convenient for you to have individual Pilates classes?

…………………………………………………………………………………………………….…………………………………………..

How did you find out about our classes? ………………….………………………………………………………………

**DECLARATION**

I hereby declare that the above data is true and factual. All new information related to changes in my health will be provided by me immediately after learning about them.

I participate in the practical part of the exercises at my own risk. I have no physical limitations, disabilities, or predispositions to injury or disease that may be aggravated by participating in Pilates exercises. I take responsibility for any injuries incurred as a result of incorrect performance of exercises during classes.

Date ………………………………… Signature……………..………………………..…………………………

**BASIC PRINCIPLES OF COOPERATION:**

Appointments are made individually and schedule can be regular or flexible.

If you need to change or cancel a class, it is required to inform the instructor at least 24 hours in advance (the sooner, the better we can plan a different meeting date for the benefit of maintaining the continuity and efficiency of the entire cycle of classes).

Cancellation of classes within a period shorter than 24 hours is associated with a fee for unused booking of classes (the on-line booking system does not return this amount to the user's profile after exceeding the time limit of 24 hours before classes).

Date …………………………………… Signature…………….……..………………………

**PLEASE NOTE**

For hygienic reasons, we recommend coming to classes with your own mat (in the room we have a universal mat, just in case). We recommend comfortable clothes for exercise. We practice in socks. (Thank you in advance for bringing a rubber band or hair clip with you if you need to tie your hair together for analysis or practice.)

It is very important to follow the rules below to assure hygiene during classes.

We recommend wearing a non-restraining outfit for physical exercises, especially one made of flexible fabrics that is most comfortable for the participant.

Participants exercise in socks (without shoes).

Participants with long and medium-long hair are asked to have their hair tied-up. Due to safety no big or hard elements of hairdo is allowed.

For the group classes -- please bring your own exercise mat. If you don’t know what mat should you buy you can borrow a mat that is available in the studio for the first classes just to try it out. (Instructors can recommend what kind of mat will be more suitable for you. They base their recommendation on their own experience and participants’ opinions. Our instructors are not cooperating with any company producing mats. Participants are required to buy the mats by themselves.)

**CONSENT**

🞏 I consent to the preparation and storage of descriptive and photographic documentation and its use for the purposes of treatment and consultation or future medical research by Pilates terapeutyczny Alicja Rukowicz as well as Strefa Równowagi Sp. z o.o.

🞏 I agree to receive information and instructions regarding my treatment by electronic means (text message, e-mail).

🞏 I consent to the storage and processing of my personal data (name, surname, address, telephone number) according to The Act of 10 May 2018 on the Protection of Personal Data by Pilates terapeutyczny Alicja Rukowicz, NIP 9521917384 as well as Strefa Równowagi Sp. z o. o., NIP : 7011058490 (All the details in Rules and Regulations : <http://pilatesterapeutyczny.pl/english/> )

Date ………………………… Signature……………..………………………

Please bring filled in questionnaire for our first classes or send them via e-mail. See you soon!