

PARQ FORM

Name:		Date:			
Date of Birth:	Age:	Height:	Weig	ht:	
Address:					
Email:					
Phone no:		Cell no:			
Profession:					
Physician Name:					
Address:					
Physician Contact Num	ber:				
In Case of Emergency C	ontact:		Relationship:		
Emergency Contact No	·				
every day. Being more a their physician before t accurately & complete	hey start becoming Iy as possible.		•		
Are you currently unde If yes, explain:				res	NO
When was the last time	e you had a physica	l examination	?		
Do you take any medica	ations and reasons	for taking:			
What is the medication	for?				
Have you been hospita	ized or had surger	y recently?		Yes	No
If yes, explain:					
How does this medicati	on affect your shill	itu to oversise	2		
	on anect your abil	ity to exercise			

Please mark yes or no to the following:	Yes
Do you smoke	
Are you pregnant or given birth within the last 6 months	
Do you drink alcohol more than three times /week	
Is your stress level high	
Are you moderately active on most days of the week	
Have you had surgery	
Do you have or had any of the following:	
High Blood Pressure	
A Stroke	
A heart murmur	
Irregular heart beat or palpitations	
Light headedness or do you faint	
Unusual shortness of breath	
Chest pain when not doing physical activity	
Lose your balance due to dizziness or do you lose consciousness	
High Cholesterol	
Diabetes	
Asthma or exercise induced asthma	
Cramping pains in legs or feet	
Emphysema	
Epilepsy	
Other metabolic disorders (thyroid, kidney, etc,)	
Back pain: upper, middle, lower	
Low blood sugar levels (hypoglycaemia)	

Do you have a bone, joint or any other health problem that causes you pain or limitations (I.e., osteoporosis, high blood pressure, arthritis, anorexia, bulimia, anaemia, epilepsy, respiratory ailments, back problems, etc.)

If you have answered yes to any of the above questions, please provide more information here:

Have parents or siblings who, prior to age 55 had:	Yes	No
A heart attack		
A stroke		
High Blood Pressure		
High Cholesterol		

Belinda: 0848888669

No

Known Heart disease			
If yes, please specify:			

Please note: If you answered YES to any of the above questions, you are advised to seek medical advice/approval before commencing an exercise induction or exercise programme, or consult further with your instructor.

I have been informed both verbally and in writing that if I answer YES to any of the questions in the above questionnaire, I should seek medical advice/approval before commencing an exercise programme and or induction. If I wish to continue without such advice, I do so entirely at my own risk. I confirm that I have read, fully understood and answered the above questions honestly. I understand that **Pilates 4 You** and any of its employees cannot be held responsible for any injuries or ill health arising from my participation.

If your health changes such that you could then answer **YES** to any of the above questions, tell your instructor.

I have read, understood, and completed the questionnaire. Any questions I had were answered to my full satisfaction.

Signed:

Date:

Consultant name: _____

Signature: