

HEALTH SCREENING QUESTIONNAIRE

The purpose of this 'Health Screening Questionnaire' is to:

- Identify individuals with a known disease, signs or symptoms of disease and/or existing pathologies who may be at a higher risk of an adverse event whilst participating in a Pilates program or Pilates classes
- Assist _____ (INSTRUCTOR'S OR BUSINESS NAME) to identify health concerns that may impede or prohibit new clients from safely participating in Pilates programs and Pilates classes
- Facilitate _____ (INSTRUCTOR'S OR BUSINESS NAME) to operate within the Pilates Australasia Alliance (PAA) Pilates Instructor Scope of Practice by ascertaining relevant health information of new clients prior to their commencement of a Pilates program or Pilates classes

As a member of the PAA and in accordance with the PAA's Pilates Instructor's Scope of Practice, _____ (INSTRUCTOR'S OR BUSINESS NAME) must obtain health information from new clients prior to their commencement of a Pilates program. _____ (INSTRUCTOR'S OR BUSINESS NAME) agrees to, but is not limited to, committing to work within the following PAA guidelines:

- Undertaking an initial consultation process by conducting a pre-exercise clearance of clients: this comprises of the client completing a 'Health Screening Questionnaire' and a 'Pre-exercise Screening and Assessment'
- Recognising conditions that may preclude a client from safely participating in a Pilates exercise program, or conditions requiring a referral, and providing information or referral to medical or allied health professionals as appropriate

The PAA considers the following to be beyond the Scope of Practice of a Pilates instructor and do not qualify _____ (INSTRUCTOR'S OR BUSINESS NAME) to engage in:

- 'Prescribing' exercises for pathologies and conditions outside the scope of a Pilates instructor without consultation with an appropriate medical or allied health professional
- 'Diagnosing' a client with any medical, mental or physical condition; training a client with a condition that is beyond the Pilates instructor's level of qualification, without appropriate medical clearance
- Claiming to 'treat' injury, pathology or disease
- Monitoring or measuring with instrumentation the progress of clients referred by therapists or medical practitioners
- Providing specific dietary advice or recommend supplements
- Offering counselling
- Claiming to be competent to offer professional education beyond the limits of the Pilates instructor's credentials
- Applying inappropriate touch
- Continuing to train a client who exhibits any of the following symptoms: Chest pain, prolonged dizziness, rapid heart rate, shortness of breath, significant decrease in coordination, loss of consciousness, faintness, nausea, blurred vision, prolonged or increasing pain

HEALTH SCREENING QUESTIONNAIRE

Full Name: _____ Sex: M / F / OTHER DOB: ____ / ____ / ____ Age: _____
Occupation (optional): _____ Tel: _____ Email: _____
Emergency Contact _____ Tel: _____

PART A: MEDICAL CONSIDERATIONS (COMPULSORY) Place an X in the box to indicate YES or NO.

1. Have you been told by your medical practitioner that you have a heart condition or that you have ever suffered a stroke?
YES ☐ NO ☐
2. Do you ever experience unexplained pains or discomfort in your chest at rest or during physical activity/exercise?
YES ☐ NO ☐
3. Do you ever feel faint, have spells of dizziness or suffer vertigo during physical activity/exercise that causes you loss of balance or to feel unwell?
YES ☐ NO ☐
4. Have you suffered an asthma attack requiring immediate medical attention at any time during the last twelve (12) months?
YES ☐ NO ☐
5. If you have diabetes (type I or type II) have you had difficulty controlling your blood glucose (sugar level) in the last three (3) months?
YES ☐ NO ☐ NOT APPLICABLE ☐
6. Do you have any diagnosed muscle, bone or joint problems that you have been told could be made worse by participating in physical activity/exercise?
YES ☐ NO ☐
7. Do you have any other medical conditions that may need to be considered for you to participate in physical activity/exercise?
YES ☐ NO ☐

If you have ticked YES to any of the above, you are advised to seek guidance from your medical practitioner or appropriate Allied Health Professional (AHP) and obtain a signed medical clearance before commencing your Pilates program or classes with _____ (INSTRUCTOR'S OR BUSINESS NAME).

PART B: MEDICAL CONSIDERATIONS (RECOMMENDED/OPTIONAL)

8. Has a family member (including parents, grandparent, uncles or aunts under the age of 55 years) suffered from heart disease, stroke, raised cholesterol or sudden death?
YES ☐ NO ☐
If YES, please specify your relationship (e.g mother) _____

9. Have you been told by a medical practitioner that you have high blood pressure?

YES ☐ **NO** ☐

If YES, are you currently taking medication to control this condition?

YES ☐ **NO** ☐

10. Have you been told by a medical practitioner that you have high cholesterol/blood lipids?

YES ☐ **NO** ☐

If YES, are you currently taking medication to control this condition?

YES ☐ **NO** ☐

11. Do you have arthritis, osteoarthritis or osteoporosis?

YES ☐ **NO** ☐

If YES, please specify the medical condition _____

If YES, are you currently taking medication to control this condition?

YES ☐ **NO** ☐

12. Do you have varicose veins?

YES ☐ **NO** ☐

If YES, are you currently taking medication to control this condition?

YES ☐ **NO** ☐

13. Do you have any abdominal disorders or bloating?

YES ☐ **NO** ☐

If YES, are you currently taking medication to control this condition?

YES ☐ **NO** ☐

14. Do you have any reproductive organ disorders?

YES ☐ **NO** ☐

If YES, are you currently taking medication to control this condition?

YES ☐ **NO** ☐

15. Are you currently taking any prescribed medication (other than those already mentioned) for any other medical conditions?

YES ☐ **NO** ☐

If YES, please specify the medical condition _____

16. Have you been hospitalised for any illness or condition (including day admissions) during the last twelve (12) months?

YES ☐ **NO** ☐

*If **YES**, please provide details* _____

17. Do you have any allergies?

YES ☐ **NO** ☐

*If **YES**, please specify the allergy* _____

18. Have you been told that you have any infectious diseases?

YES ☐ **NO** ☐

*If **YES**, please provide details* _____

19. Do you have any other pathologies or ailments (other than those specified above) that may impact your ability to engage in a Pilates program or classes?

YES ☐ **NO** ☐

*If **YES**, please provide details* _____

20. Are you pregnant (**if you are pregnant, it is advised that you discuss engaging in a Pilates program or classes with your medical practitioner or obstetrician prior to commencing training**)?

YES ☐ **NO** ☐

*If **YES**, how many weeks?* _____

21. Have you given birth within the last twelve (12) months?

YES ☐ **NO** ☐

*If **YES**, when did you give birth?* _____

22. Do you smoke?

YES ☐ **NO** ☐

*If **YES**, how many per day or week?* _____

23. Do you currently engage in regular physical activity?

YES ☐ **NO** ☐

*If **YES**, please specify the activity/activities and the frequency per week?* _____

24. Have you been diagnosed with any bone, muscle, tendon, ligament or joint pathologies that could be compromised by participating in physical activity?

YES ☐ **NO** ☐

*If **YES**, please provide details* _____

25. Do you have any specific goals related to your Pilates training?

YES ☐ **NO** ☐

*If **YES**, please specify* _____

I _____ (NEW CLIENT'S NAME) agree that the information provided by me in this 'Health Screening Questionnaire' (Part A and Part B) is true and accurate and will be used as a guideline to the limitations of my ability to participate in a Pilates program and Pilates classes. I understand that it is for the purpose of assisting _____ (INSTRUCTOR'S OR BUSINESS NAME) with the provision of safe Pilates practice with the understanding that I consider myself both physically and mentally sound and able to participate in Pilates at my own risk. I agree to notify _____ (INSTRUCTOR'S OR BUSINESS NAME) immediately if during any exercise I experience pain or discomfort. I recognise that this 'Health Screening Questionnaire' does not provide advice of any kind, nor does it substitute the advice of a qualified medical practitioner. No warranty of safety should result from its use nor does it in any way guarantee against injury or death. _____ (INSTRUCTOR'S OR BUSINESS NAME) will not accept responsibility or any liability whatsoever for any loss, damage, injury or death arising from any person acting on information provided in this 'Health Screening Questionnaire'. The information I have provided is confidential and will not be shared with any third parties without my prior consent unless required by law.

Name: _____ Signature: _____ Date: ____/____/____

The PAA accepts no responsibility or liability whatsoever for any loss, damage, injury or claim that may arise from any person acting on any information provided in this 'Health Screening Questionnaire'. No warranty of safety should result from its use nor is a guarantee against injury or death assumed by the PAA.