Wilmington Wellness Studio, LLC 910.796.9690

Health Screening Form

Name: _____
Address: _____
_____
Phone number: _____
Email address: _____
Date of birth: _____
Gender: _____

Have you ever been treated by a physician or experienced any of the following conditions?

___ heart disease
___ high blood pressure
___ low blood pressure
___ gastric reflux
___ glaucoma
___ orthopedic/joint (shoulder/elbow/spine/hip/knee) problems
___ osteoporosis
___ arthritis
___ peripheral neuropathy (numbness/tingling/diminished sensation)

Please explain any of the above conditions in greater detail.

Are you pregnant? Yes ____ No _____Prior deliveries_____
Prior surgeries
_____
_____

Prior injuries
_____
_____

Do you carry a list of your current medications? Yes No

Activity level/exercise frequency at current time?
_____
_____

Any prior movement experience? (dance, yoga, Feldenkrais, Pilates, etc.?)
_____
_____