



## Health Summary and Waiver

1. Name: \_\_\_\_\_

D.O.B: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (home): \_\_\_\_\_ (mobile): \_\_\_\_\_

E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_

In Case of Emergency, please contact \_\_\_\_\_

Phone (home): \_\_\_\_\_ (mobile): \_\_\_\_\_

2. Have you practiced Pilates before? Yes Mat Classes or Apparatus? No

3. What Results would you like to achieve from practicing Pilates? \_\_\_\_\_

4. Are you exercising now? Yes No If yes, what type(s) of exercise(s): \_\_\_\_\_

5. Prior movement experience: Dance, yoga, aerobics, etc \_\_\_\_\_

6. Describe any accidents or injuries you had in the past: \_\_\_\_\_

7. Describe any current injuries you might have: \_\_\_\_\_

8. Are there any other conditions that may be reason to modify your exercise program? Yes No

9. Are you currently undertaking any treatment/physical therapies? Yes No

10. Have you been hospitalized in the last 6 months? Yes No

12. Are you pregnant or had a baby within the last 8 weeks? Yes No  
Due (congratulations!) on Date \_\_\_\_\_



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13. Have you ever had undiagnosed pain in the following:

Neck		Hips/Pelvis		Arms			
Shoulders		Knees		Elbows			
Back		Feet/Ankles		Abdomen			
Wrists/Hands		Other					

If you have any conditions and injuries that still need to be diagnosed or cleared, please seek medical clearance from your doctor to exercise OR sign below if you have cleared the above condition/s with your doctor

Condition/s: \_\_\_\_\_

Approximate date cleared: \_\_\_\_\_

Signature: \_\_\_\_\_

**PLEASE READ CAREFULLY AND INITIAL.**

**24-HOUR CANCELLATION POLICY:**

I understand that if I must cancel a scheduled appointment or class, I must notify the instructor 24 hours in advance or I will be held responsible for payment. The instructor will work hard to stay on schedule. We respect and honor your time and we ask you to do the same.

We allow 2 emergency cancellations per year. *Please initial:* \_\_\_\_\_

**PACKAGE EXPIRATION POLICY:**

All *packages* have a **12-month expiration date**. This policy is to encourage you to be consistent and to commit to your fitness and health goals. *Please initial:* \_\_\_\_\_

◦ I understand that Pilates work I receive is provided for the purpose of improving my fitness, relaxation, stress reduction, relief of muscular tension, and/or the balancing/aligning of the body. If I experience any pain or discomfort during this/these session(s), I will immediately inform the instructor so that the effort and/or exercise may be adjusted to my level of comfort. I understand that in session situations if I feel discomfort and/or pain, I will stop and inform the instructor.

◦ I understand that a medical evaluation is advisable before beginning any program of physical conditioning or exercise. I have or will continue to keep the instructor informed of any physical condition or disability, which would prevent or limit my participation in an exercise, physical conditioning, and/or bodywork. I acknowledge that, although the Pilates I participate in may have substantial physical benefits, the instructor is not engaged in diagnosing or treating medical diseases or deficiencies, nor do sessions serve as a substitute for medical diagnosis or treatment when such attention is needed.

◦ Because Pilates is contraindicated (should not be done) under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the instructor updated to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so.

◦ I expressly assume all risks of participation in Pilates. I recognize that though many positive changes can occur as a result of Pilates, there is the possibility of negative side effects including possible short-term aggravation of some symptoms, tiredness, light-headedness, decreased energy, etc.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Parent or consenting adult if a minor: \_\_\_\_\_