Re:Align Pilates

Client Registration and Assessment Form

All information is kept strictly confidential and will not be released without your authority

PERSONAL DETAILS

Name:_____

Address:_____

Post Code:_____State:_____

Home Telephone:_____

Mobile:_____

Email:_____

Gender:_____

Date of Birth:_____

Age:_____

Height:_____

Weight:_____

Occupation:_____

EMERGENCY CONTACT DETAILS

Name:_____

Home Telephone:_____

Mobile:_____

Relationship to you:_____

PHYSICIANS CONTACT DETAILS

I give permission for the Pilates studio to contact my physician for any additional information they may require **YES** **NO**

Physicians Name:_____

Address:_____

Telephone :_____

PART 1: BACKGROUND AND HEALTH

1) i) Will this be the first time you have practiced Pilates? **YES** **NO**
ii) If you have done Pilates before please indicate: **STUDIO** **MAT**
iii) Previous classes attended **0-10** **10-20** **20+**

2) Does your work/ leisure activities involve any of the following? (Please tick)
a) Lifting or moving heavy objects ○ **YES** ○ **NO**
b) Frequent bending ○ **YES** ○ **NO**
c) Sitting for long periods ○ **YES** ○ **NO**
d) Driving ○ **YES** ○ **NO**
e) Standing ○ **YES** ○ **NO**
f) Other repetitive actions ○ **YES** ○ **NO**

3) **Females Only**
Pregnancy History
i) Are you or could you be pregnant now? **YES** **NO**
ii) If YES when is your due date? _____
iii) Have you had any previous pregnancies **YES** **NO**
iv) How was your baby delivered? **Normally** **Caesarean** **Forceps**
v) Other issues? _____

4) **Conditions**

Do you have or have you suffered from the following conditions (Please tick)

o Diabetes	o High Blood Pressure	o Low Blood Pressure	o Heart Trouble
o Asthma	o Epilepsy	o Osteoporosis/ Arthritis in joints	o Joint Replacement
o Neck Pain	o Back Pain	o Scoliosis	o Headaches/ Migraine
o Smoker	o Numbness/ Tingling	o Cancer	o Surgery
o Recent fracture	o Tendinitis	o Stress Anxiety	o Pinched nerve
o Hypermobile joints	o Major Accident	o Digestive Complaints	o Herniated Discs
o Bone/ Stress fracture	o Knee/ Hip Problems	o Shoulder/ Elbow/ Wrist Problems	o Foot/ankle problems (Orthotics)

o Long standing medical conditions ie)Parkinsons, MS

If you have ticked any of the above conditions please provide further information.

_____

_____

Other information

i) Is there any other information or conditions not listed above that your Pilates instructor should be aware of? _____

ii) Please advise us of any medications or medical treatment you are currently taking:

_____

iii) List other forms of exercise have you performed in the past?_____

_____

PART 2 : YOUR AIMS

1) What are your reasons for taking up Pilates?_____

_____

PART 3 : TERMS AND CONDITIONS

- You will be charged a cancellation fee of one session if you do not provide Re:Align Pilates with one days notice of your absence. If you change your appointment for another time that week no charges will apply.
- The Pilates programme devised for you is based upon sound teaching practice and information you have provided about yourself.
- You must therefore inform the studio of any changes to your medical conditions as soon as you become aware of them.
- If you experience any pain or dizziness during any class it is your responsibility to inform the instructor as soon as possible.
- All reasonable care is taken by Re:Align Pilates to ensure your safety, however you will take full responsibility for your actions in the studio.
- In the event of an emergency, you give permission for the studio to seek medical attention on your behalf.
- Re:Align Pilates accepts no liability for any injury or death relating to participation in Pilates unless caused directly from the negligence of one of the instructors.
- I confirm that I have read and understood the above conditions and that the information I have provided is correct.

Client Signature _____ **Date** _____