

**CLIENT CONTACT INFORMATION – PLEASE PRINT CLEARLY**

Date of First Session: \_\_\_\_\_

How did you hear about the studio? \_\_\_\_\_

Full Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Company: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

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

Person to contact in case of emergency: \_\_\_\_\_  
(Name & Phone No.)

Physician: \_\_\_\_\_  
(Name & Phone No.)

## MEDICAL INFORMATION

(If Indicating issues, please specify particulars on a separate page)

- Back Problems
- Osteoporosis
- M.S.
- Arthritis
- Carpal Tunnel or Repetitive Strain Injury
- Balance problems
- Medications
- Allergies
- Heart Attack, heart disease, cardiac surgery
- Diabetes
- Epilepsy or seizures
- Blood pressure problems
- Migraines or recurrent headaches
- Swollen, stiff, or painful joints
- Lightheadedness or fainting
- Asthma
- Stomach or intestinal problems
- Hernia
- Bursitis
- Other (Details of Hip, Shoulder, Knee or Foot issues on a separate page)

Are you presently engaged in regular exercise or physical activity?  No  Yes Activity:

Duration:

Frequency:

Intensity:

Have you had a recent medical examination? Were the results satisfactory?  Yes  No

How would you describe your eating habits:  Excellent  Good  Fair  Poor

How would you characterize your lifestyle:  Highly Stressful  Moderately Stressful  
 Low in Stress

How would you describe your sleep patterns:  Excellent  Good  Fair  Poor

Goals:

CONSENT FORM

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

I, \_\_\_\_\_, declare that I intend to use some of all the activities, facilities, programs and services offered by Pacific Spirit Pilates Inc. that are based primarily on the Pilates Method of Conditioning and I understand that each person (including myself) has a different capacity for participating in such activities, facilities, programs and services. I am aware that all activities, services and programs offered are educational, recreational, or self-directed in nature. I assume full responsibility during and after my participation for my choices to use or apply, at my own risk, any portion of the information or instruction I receive.

I understand that part of the risk involved in undertaking any activity or program is relative to my own state of fitness or health (physical, mental or emotional) and the awareness, care and skill with which I conduct myself in that activity or program. I acknowledge that my choice to participate in any activity, service and program with Pacific Spirit Pilates Inc. bring with it the assumption by me of those risks or results stemming from this/these choice(s) and the fitness, health, awareness, care and skill that I possess and use.

I recognize that by participating in the activities, facilities, programs and services offered by Pacific Spirit Pilates Inc. that I might experience potential health risks such as transient light-headedness, fainting, abnormal blood pressure, chest discomfort, leg cramps and nausea and that I assume willfully those risks. I acknowledge my obligation to immediately inform one of the practitioners of any symptoms of distress or abnormal response.

I understand that I may ask any question or request further explanation or information about the activities, programs and services offered by Pacific Spirit Pilates Inc. at any time before, during or after my participation.

In Consideration of my participation in Pacific Spirit Pilates Inc. programs and/or private or semi-private instruction, I hereby release Pacific Spirit Pilates Inc. from any liability now including, but not limited to, heart attacks, muscles strains, pulls or tears, broken bones, shin splints, or injury, however caused, occurring during or after my participation in the exercise program or personal instruction.

I declare that I have read, understood and agree to the contents of this informed Consent Agreement in its entirety.

Name \_\_\_\_\_ Signature \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

Phone Numbers \_\_\_\_\_  
(Home) (Cell) (Work)

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

PLEASE NOTE

1. Cell phones are to be turned off during your session or class.
2. All registered classes are non-transferable.
3. If you book a private session, your appointment time is reserved for you. If you are unable to keep this appointment, please call 24 hours in advance, in which case no charge will apply.
4. Please refrain from wearing perfume or strongly scented fragrances in group classes.