

pilatesinmoray

Client Enrolment Form

Name:
Address:
Postcode: Date of Birth:
Home Tel: Work Tel:
Mobile: Email:
Doctors Name: Address: Dr's Tel #:
Emergency Contact Name: Contact Tel #:
Occupation:
Hobbies / Sports:

(Please circle your answers)

1. Is your blood pressure: High / Low / Normal
If **high** is it controlled with medication? YES / NO
2. Do you suffer from any heart trouble or defect? YES / NO
If **yes** please give details.....
3. Do you suffer from chest pain either at rest or during physical activity? YES / NO
If **yes** please give details:
4. Do you have asthma, diabetes or epilepsy? YES / NO
If **yes** please give details.....
5. Are you or have you been pregnant in the last 6 months? YES / NO
If **yes** please give details.....
6. Do you suffer from back or neck pain? BACK / NECK
If **yes** please give details.....
7. Do you have arthritic joints, excessive joint mobility (hypermobility), osteoporosis, osteopenia or any other bone, joint or inflammatory conditions? YES / NO
If **yes** please give details.....
8. Do you have pain in any other joint/s or in any movements? YES / NO
(e.g. knee, wrist, shoulder, ankle, kneeling, raising arm, bending forward or to the side etc...)
If **yes** please give details.....

PTO/....

9. Do you have any other medical conditions? YES / NO
If **yes** please give details.....
10. Are you taking any medication? YES / NO
If **yes** please give details.....
11. Have you had any surgery recently or in the past? YES / NO
If **yes** please give details.....
12. If you have answered **yes** to any of **Q's I-II** do you have medical clearance to exercise? YES / NO
13. Have you ever suffered any injuries, accidents or fractures? YES / NO
If **yes** please give details.....
14. Do you have any allergies or digestive problems? YES / NO
If **yes** please give details.....
15. Are you currently being treated or been recommended to try Pilates by a specialist /health professional (e.g. GP, Physiotherapist, Chiropractor, Osteopath)? YES / NO
If **yes** do you give us permission to contact them if necessary YES / NO
If **yes**: Name: Profession: Contact No:

16. What would you like to achieve from your Pilates sessions?.....

.....
Please use the space below to give any more information you feel we should be made aware of:

IMPORTANT NOTES BEFORE YOU BEGIN....

- It is wise to check with your Doctor before starting a new exercise regime.
- You will need clearance to exercise from your Doctor **prior to starting** if you have answered **yes** to any of **questions I-II** above.
- It is not recommended to take up Pilates between weeks 8 to 14 of pregnancy, unless specially arranged with your teacher and with medical clearance. It is also recommended to wait 6 weeks post birth along with GP/Midwife consent before starting or returning to sessions.
- It is important to inform your teacher before your session if your health or ability to exercise changes at any time.
- It is important to listen to your body and work at a pace that is comfortable for you, please advise your teacher if you experience any discomfort or pain during or after a session.
- The teacher can accept no liability for personal injury during a session if your doctor has advised you against participating, you don't follow the teacher's guidance on technique, exercise suitability & safety or if injury is caused by another class member.
- Pilates tuition can include hands on cueing, do you give permission for your teacher/s to work in this way? **Yes / No**

I have read and understood the guidance above and the information I have given is correct.

Signed: Client: **Date:** **Teacher:** **Date:**

DATA PROTECTION

- **We request your consent** to contact you with our Pilates based information. You have the right to **'opt out'** at any time.
- The details on this form and information you provide are stored securely and used in confidence, for tuition purposes and communicating Pilates relevant information with you. They are kept for the amount of time necessary to satisfy legal and insurance requirements and will not be shared with third parties without your written permission.

I give my consent to being contacted and agree to the information above.

Print Name: **Signature:** **Date:**