

ABN 28104159837  
 Newtown Business Centre  
 Suite 3, 1 Erskineville Road  
 Newtown NSW 2042  
 Phone (02) 9519 4913  
 Fax (02) 9516 5463

**NEW CLIENT FORM - PILATES**

Given Name:			
Address:			
	Post Code:		
Contact Details:	Phone :		
	Email:		
Emergency Details :	Name		
	Phone:		
	Email:		

**Medical History** – Have you ever had or currently have any of the following (please mark)

	Yes	No		Yes	No
Arthritis / Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bone Degeneration *	<input type="checkbox"/>	<input type="checkbox"/>
Slipped / Bulging Vertebral Disk *	<input type="checkbox"/>	<input type="checkbox"/>	Hernia *	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain / Injury *	<input type="checkbox"/>	<input type="checkbox"/>	Asthma / Breathing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Upper Back Pain / Injury *	<input type="checkbox"/>	<input type="checkbox"/>	Recent Pain / Tightness in Chest	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain / Injury *	<input type="checkbox"/>	<input type="checkbox"/>	High / Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Lower Back Pain / Injury *	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Pain / Injury *	<input type="checkbox"/>	<input type="checkbox"/>	Heart Diseases / Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic Floor Conditions *	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Illness *	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes *	<input type="checkbox"/>	<input type="checkbox"/>	Recent Surgery *	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

If you ticked yes to any of the above – please give details

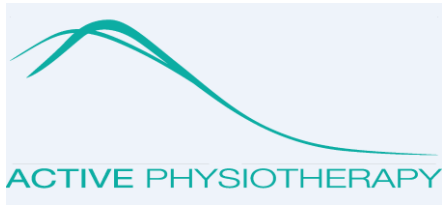
Are you Currently taking any prescription Medication? Please give details.	<input type="checkbox"/>	<input type="checkbox"/>
Smoker:	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently participate in regular Exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever trained or are training at an elite or competitive level in any sport or exercise?	<input type="checkbox"/>	<input type="checkbox"/>
What do you wish to achieve through Exercise?		

**For your safety you may be required to seek medical advice before commencement of Classes with Form Pilates and Studio.**

**Thank you for taking the time to read and fill this form in.  
 This form must be returned signed and Dated before your first lesson.**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PLEASE NOTE THAT THIS INFORMATION IS STRICTLY CONFIDENTIAL**



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**LIABILITY & INDEMNITY WAIVER – PILATES**

I consent to voluntarily participate in health and fitness services provided by Active Physiotherapy and Form Pilates at my own sole risk and responsibility; this includes, but is not limited to the following activities:

Pilates Floor Classes (with small props), Pilates Apparatus Classes, Pilates Fitball Classes, Pilates Pregnancy and Post Natal Classes, Pilates Personal Training, Pilates Barre Classes, Pilates Classes of any kind Out Doors, and Pilates of any kind at my own home or your own home premise, or the studio premise.

The level of exercise that I will perform will be at my own pace, based upon my cardio respiratory (heart and lungs) fitness, muscular strength, endurance and limitations. I understand that there are risks that may be associated with any form of exercise. I hereby agree that prior to my participation I will inform Form Pilates of any known medical conditions or factors that may put me at risk, for which Form Pilates will need a medical release from my medical practitioner prior to participation. I will inform Form Pilates of any symptoms before during and after participation that occur such as fatigue, shortness of breath, chest discomfort, or any pain or discomfort for my safety and benefit.

Active Physiotherapy and Form Pilates shall not undertake any obligation (whether contractually, at common law or otherwise) to advise or treat me in relation to any of the matters referred to in the preceding paragraph. I acknowledge that it is my obligation and mine alone to take responsibility for my health and wellbeing during any type of exercise I undertake with Active Physiotherapy and Form Pilates.

I will be given tuition on how to perform exercise and will direct any questions to Active Physiotherapy and Form Pilates. Active Physiotherapy and Form Pilates will monitor my performance and otherwise evaluate my effort.

I acknowledge and agree that infants and minors are the sole responsibility of their parents / guardian not Active Physiotherapy and Form Pilates. It is and will remain my personal duty to care for any infant and minors in my custody and Active Physiotherapy and Form Pilates shall not be liable in any infant or minor in my custody is injured in any way.

I acknowledge that any type of exercise involves risk or injury. Active Physiotherapy and Form Pilates shall not be liable for any injuries or damage to me, or my property, or be subject to any claim, demand, injury, or damages whatsoever, including without limitation, damages resulting from acts of active or passive negligence (claim). I release Active Physiotherapy and Form Pilates from all liability caused by or arising from any claim.

Active Physiotherapy and Form Pilates shall not be liable or responsible to me for articles lost, damaged or stolen from any of its studios, or at my home.

This waiver may be pleaded in response as a bar to any legal proceeding taken by me or on my behalf, in a breach of this waiver.

I acknowledge that I have read and understood this document and shall identify and keep Form Pilates indemnified against any losses arising from a breach of this waiver.

Any Reference to Active Physiotherapy and Form Pilates includes its agents, employees, contractors and Form Studio.

Name: (Print) \_\_\_\_\_ Signature: \_\_\_\_\_

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

\_\_\_\_\_ Tel: \_\_\_\_\_

If participant is under 18: As legal guardian of the above I consent to the above terms and conditions.

Names Parent /Guardian: (Print) \_\_\_\_\_ Signature: \_\_\_\_\_

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

\_\_\_\_\_ Tel: \_\_\_\_\_

PLEASE NOTE:  
Terms and conditions are subject to change without notice.