



HEALTH HISTORY QUESTIONNAIRE

ALL QUESTIONS MUST BE COMPLETED BEFORE BEGINNING ANY EXERCISE, PLEASE COMPLETE ALL PAGES ON FORM.

Personal Information

1. Name _____ Today's Date _____
2. Local Address _____
City _____ State _____ Zip _____
3. E mail _____
4. Mobile Phone _____ Home Phone _____
5. Seasonal Client **YES** ____ **NO** ____
If No, Continue to question 6
If Yes then provide your Permanent Address _____
City _____ State _____ Zip _____
6. Date of Birth _____ Height _____ Weight _____
7. Name of Person to contact in the case of an emergency _____
Relationship _____ Phone _____
E mail _____
8. How did you hear about us?
() Another Client/Friend _____ () Commercial () Internet () Mailer () Newspaper () Radio
() Ram Realty () Staff Member () Walk In () Yellow Pages () Other
9. Do you have your Physician's clearance to exercise? **YES** ____ **NO** ____
If No, Please speak with your instructor before proceeding.
10. Are you under the care of a physician at this time? **YES** ____ **NO** ____
If No, Continue to question 11
If Yes then provide your Physician's Name _____ Phone _____
11. Do you take any prescribed medications on a regular basis? **YES** ____ **NO** ____
If No, Continue to question 12
If Yes then please list any/all medications and reasons for taking _____

12. What do you hope to gain from coming to Pilates Rocks? (Please check all that apply)
 Sports Training Muscle Tone Improve Self Esteem Weight Loss Functional/Core Training General Fitness
 Decrease Medication Dependency Improve Posture Pain Management Improve Flexibility
13. Are you presently involved in a regular exercise program? **YES** ____ **NO** ____
If No, Continue to question 14
If Yes then please list activity, duration and frequency and intensity _____

14. Have you ever worked with a personal trainer? **YES** ____ **NO** ____
If No, Continue to question 15
If Yes, How often and how long ago? _____
15. Do you have any Pilates, Yoga or Gyrotonic® experience? **YES** ____ **NO** ____
If No, Continue to question Medical History Section
If Yes, please describe _____

Medical History

Check those questions to which you answer yes. Leave others blank. Check off the issues that currently have or have had in the past.

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Attack/Coronary Bypass/Other Cardiac Surgery | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Recent Surgery | <input type="checkbox"/> Stroke | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Stomach or Intestinal Problems | <input type="checkbox"/> Phlebitis/Emboli |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ankle Problems | <input type="checkbox"/> Trouble Sleeping |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Knee Problems | <input type="checkbox"/> Increased Anxiety or Depression |
| <input type="checkbox"/> Chest Discomfort | <input type="checkbox"/> Hip Problems | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Extra/Skipped/Rapid Heart Beats or Palpitations | <input type="checkbox"/> Back Problems Upper/Middle/Lower | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Shoulder Problems | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Migraine or Recurrent Headaches | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Lightheaded or Fainting | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Swollen/Stiff/Painful Joints | <input type="checkbox"/> Unusual Shortness of Breath | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Auto Immune Disease |
| <input type="checkbox"/> Foot Problems | <input type="checkbox"/> Emotional Disorders | <input type="checkbox"/> Night-Time Leg Cramps |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Limited Range of Motion in Joints | <input type="checkbox"/> Other (please specify) |

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN _____

Agreement of Release & Waiver of Liability

I, _____, hereby agree to the following:

(Please print name)

1. That I am participating in the Pilates Stretching and Fitness Classes, Programs or Workshops offered by Pilates Rocks LLC, their owners, staff, apprentices, during which I will receive information and instruction about Pilates, Stretching and Fitness. I recognize that Pilates, Stretching and Fitness Classes, Programs or Workshops require physical exertion which may be strenuous and may cause physical injury and I am fully aware of the risks and hazards involved.
2. I understand that it is my responsibility to consult with a physician prior to and regarding my participation in the Pilates, Stretching and Fitness Classes, Programs or Workshops. I represent and warrant that I am physically fit and I have no medical condition which would prevent my full participation in the Pilates, Stretching and Fitness Classes, Programs or Workshops.
3. In consideration of being permitted to participate in the Pilates, Stretching and Fitness Classes, Programs or Workshops, I agree to assume full responsibility for any risks, injuries or damages, known or unknown which might occur as a result of participation in the program.
4. In further consideration of being permitted to participate in the Pilates, Stretching and Fitness Classes, Programs or Workshops, I knowingly, voluntarily and expressly waive any claim I may have against Pilates Rocks LLC, their owners, staff or apprentices, for injury or damages that I may sustain as a result of participation in the aforementioned programs.
5. I, my heirs or legal representatives, forever release, waive, discharge and covenant not to sue Pilates Rocks LLC, their owners, staff, apprentices, for any injury or death caused by their negligence or other acts.

I have read the above release and waiver of liability and understand its contents. I voluntarily agree to the terms and conditions stated above.

DATE

SIGNATURE of PARTICIPANT

(OR Parent/Legal Guardian, if participant is under 18 years)

____ WITNESS (Initials)

Policies & Procedures

GENERAL _____ (initials)

All classes and sessions must be paid for in advance. Cash, checks and all major credit cards are accepted. Packages are tracked electronically and debited as sessions are used. **All class and session packages (5 & 10 pack) expire 1 year from the date of purchase. No transfers. No refunds.**

Gift certificates are available upon request. Fees, class schedules and instructors are subject to change.

CANCELLATIONS _____ (initials)

Privates

- Without 24 hour notice ALL cancellations, no shows and rescheduled sessions will be charged at full rate. The session will be automatically debited from the client's package in the computer.
- With at least 24 hours notice there will be no charge.

Duets

- When one person cancels WITH notice the remaining student EITHER takes the session and pays \$30 for the missing student OR chooses to cancel altogether.
- When one cancels WITHOUT 24 hours notice, the missing student forfeits their session and the other student takes the lesson as scheduled with no additional charge to them.

Group Class Packages

- Without 4 hours notice ALL cancellations and no shows will be charged at full rate. The class will be automatically debited from the client's package in the computer.

Monthly Unlimited

- Without 4 hours notice ALL no shows will be charged a \$10.00 fee. The charge will be debited from the client's credit card on file at the end of the month.

REFERRAL POLICY _____ (initials)

As a thank you, all current clients will be rewarded for referring clients to us as follows:

When your referral signs up for:

Any package of 10 classes or monthly unlimited

Any package of privates or duets, 5 pack

Any package of privates or duets, 10 pack

You Receive:

\$30 account credit

\$40 account credit

1 Free

NOTE: Account credits can be used towards the purchase of future sessions/classes or given to a friend in the form of a gift certificate.

GUEST PROCEDURES _____ (initials)

Private clients bringing in a guest to work out as a duet will be charged \$40 in addition to their regular session fee. All guest must complete health history forms and waivers prior to working out. If the guest is going to take more than one session they must purchase their own package.

STUDIO ETIQUETTE _____ (initials)

DRESS CODE:

1. Men should wear shorts that have a modesty liner, bicycle shorts or lightweight sweatpants.
2. Ladies tops must cover the midriff no bare skin on the apparatus.
3. Recommended to wear close fitting clothing nothing too baggy.
4. Please no perfumes or colognes this can be offensive to other students.
5. Please no lotions on hands or any exposed skin this presents a slip and fall potential in many exercises and leaves a residue that endangers the next student working on the apparatus.

GENERAL ETIQUETTE:

1. All cell phones must be silenced upon entering the studio
2. Arrive at least 5 minutes prior to your class/session start time.

I, _____, have read, understood and agree to the above policies and procedures.

(Please print name)

Signed _____

Date _____

