

CLIENT POLICY

Joy of Pilates

To ensure a quality experience here at Joy of Pilates, we ask that you as a client, consider these policies:

1. 24-hour notice is required to cancel a private or duet session. If cancellation occurs with less notice, you will need to pay for your session.
2. Please do not come to class or your private session if you are sick. If missing a private session, it is best to contact the studio. You will not be charged for your session if you are sick and need to miss.
3. Please do not get on any of the equipment unless you are with your trainer.
4. It is your responsibility to inform your instructor of any injuries which may be exacerbated by movement taught in your class or private session. Please tell your instructor, we will be able to find variations of movement that are suitable for your body and injury.
5. All class punch cards expire in 90 days. Private training packages expire in one year from purchase.
6. There are no refunds on package purchases unless a Doctor's statement is provided [clarifying that patient cannot participate in Pilates exercise]. Packages can be transferred to other clients.
7. Class will start on time – please do not be late. If you are late, you may miss important warm-up exercises that ensure a safe class.
8. **Have fun and let us know of anything we can do to serve you better! Thank you!**

I have reviewed the above policies and understand and accept them.

Signature: _____ Date: _____

Print Name: _____



WAIVER OF LIABILITY

Joy of Pilates

1. There is a risk of injury when training at Joy of Pilates.

I recognize that Joy of Pilates offers personal fitness services that require strength, flexibility and aerobic exercise. The training includes the use of equipment and exercises that may cause injury. I have been informed of and understand the risk of such an injury and in consideration for being allowed to participate in activities at Joy of Pilates do hereby release the studio, its employees, and others acting on its behalf from any claims or liabilities for injuries or damages to my person arising from my participation in those activities.

2. I am physically sound.

I hereby declare myself to be physically sound and suffering from no condition or impairment that would prevent my safe participation in the physical activities offered by Joy of Pilates. I agree to keep my instructor informed of changes to my physical condition or changes in my ability to perform the activities associated with my training.

3. I have had a recent physical examination.

I acknowledge that it is recommended that I have a yearly or more frequent physical examination and consultation with my physician regarding physical activity, exercise and use of exercise equipment. I have either 1) had a physical examination and been given my physician's permission to participate in Joy of Pilates activities or; 2) decided to participate in these activities without the approval of my physician and assume responsibility for that participation.

Signature: _____ **Date:** _____

Print Name: _____



FIT FORM

Joy of Pilates

How many days a week on average do you exercise? How long? What intensity?

Do you have any prior training in Pilates? Dance? Yoga? Martial Arts? Sports?

How long do you sit on average per day? If you work what type of job is it?

Does anything "hurt/ache" in your body? What? When? How long has it hurt you?

How would you describe your posture and flexibility?

Do you currently receive any other therapy? Body work? From whom?

May we contact your other health care practitioner(s)?

What do you want to achieve/ your goals through Pilates? **One-year health goals?**

Additional information/comments you want us to know:

Address: _____ **Zip:** _____

Phone # _____ **#** _____

E-MAIL: _____

How Did You Hear About Us? _____



HEALTH HISTORY

Joy of Pilates

In order to design a safe and effective program it is important that you complete the following Health History form. It is crucial that you answer all of the questions honestly and to the best of your ability. Please be advised that all information is kept strictly confidential.

A. Check the appropriate response.

- | | | |
|--|-----|----|
| 1. Has your doctor ever told you that you have heart problems? | Yes | No |
| 2. Has your doctor every told you that you have high blood pressure? | Yes | No |
| 3. Have you ever had a stroke or a heart attack? | Yes | No |
| 4. Have you ever had pain in your chest? | Yes | No |
| 5. Do you ever feel faint or have dizzy spells? | Yes | No |
| 6. Have you had surgery in the last six months? | Yes | No |

B. Circle any conditions which apply.

Diabetes	Epilepsy	Blood Pressure	Pregnancy (date):
Asthma	Arthritis	Osteoporosis/ Osteopenia	
High Cholesterol	Heart Disease	Cancer (type?)	

C. Have you injured or have pain in the following areas?

Neck	Upper Back	Shoulders L/R
Elbows	Lower Back	Hips L/R
Wrists L/R	Knees L/R	Feet/Ankles L/R

D. Are you currently taking any medications? Yes No

If yes, which medications, and for what conditions?

E. Are you currently undergoing treatment from any of the following:

Physical Therapist	Occupational Therapist	Massage Therapist
Chiropractor	Acupuncturist	Other?_____

F. Are there any other reasons (health or personal) that may prevent or limit you from exercising?

G. Additional information/ comments:

Signature: _____ Date: _____

Print Name: _____