

Client Registration & Informed Consent

Date: _____

First Name: _____ Middle: _____ Last Name: _____

Is there a nickname you prefer us to use? _____

Street Address _____

City and State _____ Zip Code _____

Mailing Address (if different than above) _____

City and State _____ Zip Code _____

Off-Cape Address (if applicable) _____

City and State _____ Zip Code _____

**Please indicate dates residing at off-Cape address: _____

Gender _____ Age _____ Birthdate ____/____/____ Height _____ Weight _____

Occupation _____

Phone Numbers: Home _____ Work _____

Cell _____ Other _____

E-Mail _____

Best time and place to reach you _____

Please tell us how you heard about Hands-On Health and/or Joe's Place True Pilates: _____

****Would you like to be included in mailings or e-mailings of newsletters or specials?** Yes _____ No _____

Emergency Contact:

Name _____ Relationship _____

Phone Numbers: Home _____ Work _____ Cell _____

Hands-On Health and Joe's Place-True Pilates recommend that all clients receive a complete physical and doctor's approval before beginning a fitness program. Any limitations require a physician's release.

Physician's Name and Address: _____

Has your physician approved your participation in a fitness program? _____

(Continued on next page.)

Please list any vitamins or supplements you are taking: _____

Please list any allergies: _____

Do you exercise (please list activities and how often)? _____

What types of movement/training/workouts have you experienced?

___ Pilates ___ Yoga ___ Dance ___ Group Fitness ___ Weight Training ___ Other: _____

Please check conditions or symptoms you currently have or have had in the past:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stress / Anxiety |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Recent Surgery |
| <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Jaw Pain / TMJ | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Recent Fractures | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Smoker | <input type="checkbox"/> Other _____ |

Please advise us of any medications you are currently taking: _____

Are you currently receiving any therapy or medical care? _____

Please list any medical conditions, surgeries, accidents, and bone, joint or muscle diseases or injuries not specified above: _____

Is there anything else we should know about you?

Informed Consent

Thank you for choosing to use the facilities, services, and programs of Hands-On Health and/or Joe's Place True Pilates. We request your understanding and cooperation in maintaining both your and our safety and health by reading and signing the following informed consent agreement.

I, _____, declare that I intend to use some or all of the activities, facilities, programs, and services offered by Hands-On Health and/or Joe's Place True Pilates and understand that each person, myself included, has a different capacity for participating in such activities, facilities, programs, and services. I am aware that all activities, services and programs offered may be 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 recognize that there is a risk of serious injury (and in extreme cases, death) associated with any fitness program. Consequently, I was advised by the staff of Hands-On Health and/or Joe's Place True Pilates to obtain the approval of my doctor before beginning a fitness program through Hands-On Health and/or Joe's Place True Pilates and have had the opportunity to do so. Before beginning this program, I also was asked by the staff of Hands-On Health and/or Joe's Place True Pilates whether I have any physical or mental limitations or whether I am taking any medications or receiving any medical treatment that might make it unsafe for me to participate in this fitness program. There are no such limitations, medications or medical treatment other than those that I have written on the attached sheet.

I understand that part of the risk involved in undertaking any activity or program is related to my own state of fitness or health (physical, mental, or emotional) and to 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 of Hands-On Health and/or Joe's Place True Pilates brings with it my assumption of those risks or results stemming from this choice and the fitness, performance, health, awareness, care, and skill that I possess and use.

I accept the fact that the skills and competencies of some employees, subcontractors and/or volunteers will vary according to their experience and that no claim is made to offer assessment or treatment of any mental or physical disease or condition by those who are not duly licensed, certified, insured, or registered, and herein employed to provide such professional services.

I recognize that by participating in the activities, facilities, programs, and services offered by Hands-On Health and/or Joe's Place True Pilates I may experience potential health risks which include, but are not limited to, transient light-headedness, fainting, abnormal blood pressure, chest discomfort, leg cramps, nausea, muscle soreness, muscle strains, and very rare instances of heart attack, stroke, or even death, and that I assume willfully those risks. I acknowledge my obligation to immediately inform the nearest supervising employee of any pain, discomfort, fatigue, or any other symptoms that I may suffer during and immediately after my participation. I understand that I may stop or delay my participating in any activity or procedure if I so desire and that I may also be requested to stop and rest by a supervising employee who observes any symptoms of distress or abnormal response.

I understand that I may ask any questions or request further explanation about the activities, facilities, programs, and services offered by Hands-On Health and Joe's Place True Pilates at any time before, during, or after my participation. I declare that I have read, understood, and agree to the contents of this informed consent agreement in its entirety.

I understand that, by signing this statement, I am agreeing not to hold Hands-On Health and/or Joe's Place True Pilates or any of its employees, owners, agents or insurers responsible for any bodily injury or property damage that I may suffer as a result of my participation in a fitness program through Hands-On Health and/or Joe's Place True Pilates, whether at Hands-On Health and/or Joe's Place True Pilates, at home, or elsewhere. As such I understand and agree that Hands-On Health and/or Joe's Place True Pilates, its employees, owners, agents or insurers shall not be liable for any bodily injury or property damage that may result either directly or indirectly from my participation in a fitness program through Hands-On Health and/or Joe's Place True Pilates..

Signature: _____ Date: _____

Signature of Parent/Guardian if under 18: _____