Pilates Registration Form

NAME ____ DATE ________________

Nickname:_____________________ Gender: Male / Female DOB: ___ / ___ / ____

ADDRESS ____

CITY ______________________________ STATE ____________ ZIP ______________

PHONE (cell)____________________ (h)_____________________ (w)______________________

EMAIL ________________________________ Occupation ___________________________

Emergency Contact: _____________________________ Phone: _____________________

Physician:_______________________________________ Phone: _____________________

How did you hear about Integrated Physical Therapy, LLC? ______________________

____

We have a 24-hour cancellation policy. Clients are responsible for 100% of the cost of Pilates service for appointments cancelled less than 24-hours in advance. The Pilates sessions are scheduled for an hour and 50 minutes of exercise is guaranteed. Integrated Physical Therapy, LLC recommends that you consult a physician prior to beginning any exercise program.

I have read the above cancellation policy and agree to pay in full for any no-show or appointments cancelled less than 24 hours in advance.

_______________________________________ __________________

Signature **Date**

Pilates Health Screening

Name: ______________________________ Date: ____________

Hobbies/Recreational Activities and Frequency: ______________________________

____

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you currently experiencing any physical problems? Is so, please explain: ____________

____

Medications: ______________________________

Previous Injuries: ______________________________

Previous Surgery: ______________________________

Are you currently receiving professional health care services (i.e. Chiropractic, Medical, Massage Therapy, Physical Therapy, Etc…): ______________________________

____

Are you currently or have you previously been diagnosed with any of the following? (Please check all that apply)

☐ Arthritis
☐ Anxiety/Depression
☐ Blood Clots
☐ Bowel/Bladder changes
☐ Cancer
☐ Circulatory Disease
☐ Chest Pain or Shortness of Breath
☐ Diabetes: Type I / Type II
☐ Dizziness
☐ Fibromyalgia
☐ Fractures
☐ Headaches
☐ Hearing / Vision Difficulties
☐ Heart Disease
☐ Heart Attack
☐ Hepatitis
☐ Herniated Disc
☐ High Blood Pressure
☐ Infectious Diseases
☐ Numbness or tingling
☐ Osteoporosis
☐ Osteopenia
☐ Pacemaker
☐ Pregnancy (currently)
☐ Stroke
☐ Weakness

☐ Other: ______________________________

Personal goals you would like to achieve at Integrated Physical Therapy?______________

____

I agree that the information given is complete and accurate to the best of my knowledge.

______________________ ____________
Signature **Date**

RELEASE AND WAIVER

I, ________________________________ voluntarily desire to participate in physical and/or rehabilitation exercise training classes conducted by Integrated Physical Therapy, LLC located at 121 Rue Louis XIV, Bldg 6, Lafayette, Louisiana 70508 and understand and agree with the following:

1. I assume full responsibility while voluntarily participating in any training class at my sole risk and shall abide by any and all rules and regulations for use of the facility which may be promulgated from time to time by its owner or Integrated Physical Therapy, LLC .
2. I am aware that there exists the possibility of certain conditions occurring during or following training and/or exercise. These conditions include, but are not limited to: mild or light-headedness, fainting, abnormalities of blood pressure or heart rate, ineffective heart function and in rare instances, heart attack and stroke. The reaction of the cardiovascular system to such activity cannot be predicted with complete accuracy.
3. It is strongly recommended that I receive medical clearance from my private physician prior to starting this or any exercise training program. This program can be designed for persons with known heart disease or those with disorders which require medical supervision however, those persons should have a direct physician referral. Integrated Physical Therapy, LLC reserves the right to deny services to those without their physicians' written consent/referral.
4. I expressly agree that I have been informed that the program involves possible risks and all exercises shall be undertaken at my sole risk and that neither Integrated Physical Therapy, LLC, nor the Officers, Directors, agents or employees shall be liable to me or any other person, for any claims, demands, injuries, damages, actions or causes of action, whatsoever, to my person or property arising out of or connected to services and/or exercises having direct relation to this facility. I do hereby release and discharge Integrated Physical Therapy, LLC thereof from all claims, demands, injuries, damages, actions, or causes of action and from all acts of active or passive negligence on the part of Integrated Physical Therapy, LLC or their officers, directors, agents or employees.

I certify that my attendance and participation in the stated activities are voluntary.

I HAVE READ THE ABOVE STATEMENT AND UNDERSTAND THE ABOVE CONDITIONS

Client's Signature: ________________________________ Date: ______________

Witness: ____ Date: ______________