



FOR OFFICE USE ONLY

Practitioner _____ Start Date _____ DB Date _____
Class Type _____

Floor Class Questionnaire

Please read and complete this form carefully. The information will be kept confidential.

PERSONAL DETAILS

Name _____ Birthdate _____ Age _____ Sex _____
Address _____ Emerg. Contact & Phone _____
Ph Home _____ Wk _____ How did you hear of us? _____
Mobile _____ May we use your contact info to inform you of future
E-Mail Address _____ events? Yes No

HEALTH HISTORY - Section I

Please mark all true statements below

- Have advice from physician not to exercise
- Unusual shortness of breath with/without mild exercise
- Pregnancy (within last 3 months)
- Dizziness/Fainting; ankle swelling; heart palpitations/racing heart beat; or a known murmur/vessel blockage
- Symptoms or history of cardio-respiratory disorders such as pain or discomfort in the heart

If you marked any of the statements in Section I, you require your physician or healthcare provider's approval before beginning your Pilates/GYROKINESIS® classes at Revolution.

HEALTH HISTORY - Section II

Please mark all true statements below

- High blood pressure (>140/90) or take BP medication.
- You a Male over 45 or a Female over 55 years old.
- Incr'd serum cholesterol (>.5mmol/l) or don't know.
- Chronic illness/condition (ex. migraine, allergies).
- Close blood relative who had a heart attack before age 55 (father or brother) or age 65 (mother or sister).
- Previous injury still affecting you (ex. hernia).
- Diabetes or take medicine to control your blood sugar.
- Taking prescription medication(s) (ex. heart med).
- Cigarette smoker.
- > 20 pounds overweight.
- Physically inactive (< 30 minutes of physical activity at least 3 days per week)

If you are INACTIVE and marked 1 or ACTIVE and marked 2 or more of the statements in Section II, we strongly advise that you seek your physician or healthcare provider's approval before beginning your Pilates/GYROKINESIS® classes at Revolution.

PREVIOUS EXPERIENCE OF PILATES/GYROTONIC®

ANY CONDITION(S) WHICH MAY LIMIT YOUR LEVEL OF ACTIVITY

CLIENT OBLIGATIONS/TERMS OF BUSINESS

In consideration of services rendered and to be rendered, I guarantee payment of this account. If I am unable to make a scheduled session and 24-hours notice has not been given, I understand a Cancellation Fee will be charged equal to the price of the session booked.

Open Floor Class Session purchases are non-refundable, non-transferable, and have a 6-month expiration from date of purchase; Beginner Course purchases are non-refundable, non-transferable and expire at the end of the course.

Signed by _____ Date _____

ACKNOWLEDGMENT RELEASE & ASSUMPTION OF RISK

This is an important document, which affects your legal rights and obligations. Read it carefully and do not sign it unless you are satisfied that you understand it. If you have any questions please seek advice.

I have read and understand all the questions on this form and have answered them truthfully and to the best of my abilities. I hereby certify that I am aware of no medical condition (except those noted) that may increase my risk of illness or injury as a result of my participation in a regular exercise program.

I respect the duty of care taken by my instructor and will inform them of any medical changes in the future. I understand the importance of communicating to the instructor if I feel any discomfort or pain during any movements.

I will respect the studio by taking care with all the equipment and any other participants within the space at the same time as myself.

I understand that all safety precautions will be observed by my instructor, but I agree to accept responsibility for any injury which may be sustained while taking part in these workouts.

Before signing this document I have read and understood it and know that it may affect my legal rights.

Signed by _____ Date _____

Where Participant is Under 18 Years of Age

I, _____ being the parent or guardian of the person named _____ hereby acknowledge and agree:

I have read the whole document and understand it. I consent to the person named in the above Acknowledgment Release participating in the activity and I am aware of the risks, dangers and obligations. I agree to release and Indemnify Revolution Pilates Studio/Neil Nabbefeld in the same manner and to the same effect and extent as if I were the person named in the Acknowledgment and Release and participating in the activity.

Signature of Parent/Guardian _____ Date _____