



FOR OFFICE USE ONLY		
Practitioner	Assessment Date	DB Date
2.....	<input type="radio"/> Private	<input type="radio"/> Seimi
3.....	<input type="radio"/> Private	<input type="radio"/> Seimi
4.....	<input type="radio"/> Private	<input type="radio"/> Seimi
5.....	<input type="radio"/> Private	<input type="radio"/> Seimi

## Initial Assessment 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 \_\_\_\_\_

E-Mail Address \_\_\_\_\_ May we use your contact info to inform you of future events?  Yes  No

Occupation \_\_\_\_\_

### HEALTH HISTORY

Please mark all true statements below (and if necessary, briefly explain)

- |   |   |
|---|---|
| <input type="radio"/> Advice from physician not to exercise                     | <input type="radio"/> Unusual shortness of breath with/without mild exercise or history of breathing problems (asthma, etc) |
| <input type="radio"/> Pregnancy (within last 3 months)                          | <input type="radio"/> Dizziness/fainting; ankle swelling; heart palpitations/racing heart beat                              |
| <input type="radio"/> Difficulties w/pregnancy or births                        |   |
| <input type="radio"/> Personal history of heart problems, chest pain, or stroke |   |
| <input type="radio"/> Close blood relative who had a heart attack before 55     | <input type="radio"/> Cigarette smoking   |
| <input type="radio"/> Increased serum chlolesterol (>5 mmohl) or don't know     | <input type="radio"/> Diabetes or take medication to control your blood sugar   |
| <input type="radio"/> High/Low blood pressure                                   | <input type="radio"/> Taking prescription medication(s) (ex. heart medication)  |
| <input type="radio"/> Chronic illness/condition (ex. migraine, allergies)       | <input type="radio"/> Previous injury still affecting you (ex. hernia)  |
| <input type="radio"/> Physically inactive (< 30 min's of activity, <3 days/wk)  |   |
| <input type="radio"/> Surgeries during the last 5 years                         | <input type="radio"/> Wear/have worn orthotics or any type of brace   |
| <input type="radio"/> Receiving regular medical treatment                       | <input type="radio"/> Family history of arthritis   |
| <input type="radio"/> Prior experience of the Pilates Method or Gyrotonic™      | <input type="radio"/> Other conditions which may modify a fitness program   |

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## EXERCISE & ACTIVITY HISTORY

Briefly summarize your current weekly activities & approximate time for each.  
(incl's walking, gardening, sport, and gym)

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## WHAT CAN WE DO FOR YOU?

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## CLIENT RESPONSIBILITIES/TERMS OF BUSINESS

In consideration of services rendered and to be rendered, I guarantee payment of this account. Minimum 24-hour notice is expected if I cannot keep my appointment. Otherwise, a Cancellation Fee may be charged equal to the price of the session booked.

Session purchases are non-refundable and have a 6-month expiration from date of purchase.

Signed by \_\_\_\_\_ Date \_\_\_\_\_

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## 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, \_\_\_\_\_ understand that certain elements of this program can be physically demanding. I am aware that strength, flexibility and aerobic exercises, including the use of equipment, are potentially hazardous activities. I also have been informed, understand, and am aware that fitness activities include a risk of injury, including a remote risk of death or serious disability, and that I am voluntarily participating in these activities and using equipment and machinery with full knowledge, understanding and appreciation of the dangers involved. I hereby agree to assume and accept any and all risks. As a condition of my enrolment I accept full and complete responsibility for my participation in the program and for my physical and emotional well being and the attainment of the goal which I have established for this program.

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

In consideration of the acceptance of my payment for participating in the activity (and to the full extent permitted by law) I agree to release and Indemnify Revolution Pilates Studio/Neil Nabbefeld as follows:

I participate in the activity at my sole risk and responsibility. I release, indemnify and hold harmless Revolution Pilates Studio/Neil Nabbefeld, its servants and agents, from and against all and any actions or claims which may be made by me or on behalf of or by other parties for or in respect or arising from any injury, loss damage or death caused to me or my property whether by negligence, breach of contract or in any way whatsoever. I also agree that in the event that I am injured or my property is damaged, I will bring no claim, legal or other wise, against Revolution Pilates Studio/Neil Nabbefeld in respect of the injury or damage. 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 Acknowledgment and Release participating in the activity and I am aware of the risks, dangers and obligations set out in the Acknowledgment and Release. In consideration of the person named in the Acknowledgment and Release being accepted to participate in the activity, I agree to release and Indemnify Revolution Pilates Studio/Neil Nabbefeld in the same manner and to the same effect and extend as if I were the person first named in the Acknowledgment and Release and person participating in the activity.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_