

Body Essentials Pilates/Yoga

Please Print. All information on this form will remain confidential.

Name: _____ Phone # (H): _____
Address: _____ Phone # (C): _____
_____ Phone # (B): _____
Postal Code: _____ Email: _____
Occupation: _____
Emergency Contact (name & phone #'s) _____
Relation to You: _____
Physician(s): _____ Date of Last Visit(s): _____
Date of Birth (m/d/y) _____

Briefly describe any previous pilates/yoga experience:

Describe what types of physical activities you currently participate in on a regular basis.

The main things I hope to gain from this Pilates/Yoga program: _____

How did you first hear about Body Essentials Pilates/Yoga?

Please outline any emotional health issues and current treatment or medications.

Please outline any physical conditions that may limit you doing pilates/yoga (eg. arthritis or other joint pain, headaches, allergies or sinus problems, muscular pain, stiffness or disorders, asthma or other respiratory disorders, cancer, diabetes, seizure disorders, glaucoma/detached retina or other eye disorders, hernias, high/low blood pressure, heart disease, scoliosis, osteoporosis or other spinal disorders, colitis or other digestive disorders, vertigo, menieres or other hearing disorders, kidney or bladder problems, fibromyalgia, chronic fatigue or sleep disorders, menopause/PMS, pregnant (include due date), post-natal, etc.): _____

Any injuries such as falls, car accidents, sporting injuries or childhood mishaps:

Any surgeries (old or new) including dates: _____

Many pilates/yoga students find gentle hands on guidance by their instructors to be very helpful to integrate proper alignment and obtain full benefit of the exercise. Please let me know whether or not you would like to receive this type of instruction.

_____ Hands-on OK _____ No, Thank you

Is there anything else you feel I should know?

WAIVER

Awareness is fundamental in doing pilates/yoga and I am fully aware that some of the exercises may be difficult or impossible for me. I understand that it is my responsibility to monitor each activity and determine whether it is appropriate for me to participate. I will seek alternative exercises with my instructor or simply choose not to do it. I acknowledge that it is also my responsibility to consult with a physician regarding any injury or condition that may affect my participation in this class.

I am responsible for advising on an ongoing basis, of any changes in my health (including pregnancy or post-natal, or injuries sustained outside the class). Of my own free will, I am choosing to participate in this class and will follow instructions for my own safety. With this awareness, I fully release Angela M. Hill, her associates and its rental facility from all present and future liability.

Signature: _____ Printed Name: _____

Date: (m/d/y) _____ Witness: _____

REGISTRATION/PAYMENT DETAILS:

I wish to sign up for the following pilates/yoga class(es) with Angela Hill of Body Essentials at PCVS, McDonnell St. Peterborough, ON

CLASS(ES) and TIME(S) _____

PAYMENT MADE BY: _____ **AMOUNT PAID:** _____

DISREGARD THE SECTION BELOW UNLESS YOU WISH FOR MY ASSISTANCE WITH FURTHER CLARIFICATION; CONCERNS WHERE I MAY NEED TO CONTACT YOUR PHYSICIAN OR OTHER HEALTH CARE PROVIDER.

PHIPA (Personal Health Information Protection Act)

In January 2004 PHIPA came into effect. I understand that as a regulated health professional Angela M. Hill, RMT (CMTO #E815), FIS, Yoga (Yoga Alliance #20590) & Pilates Teacher can advocate on my behalf with my written consent. This would only be done should clarification be required to confirm any of my conditions/concerns. This would authorize her to share or collect only pertinent information regarding my health care with other health providers such as physicians, physiotherapists, psychotherapists, occupational therapists, diagnostics such as x-rays, catscans, etc. and its direct relationship to my participation in a pilates/yoga class. At no time will information be provided to any other parties eg. insurance companies without written consent by myself. I hereby give consent by signing below.

Signature: _____ Printed Name: _____

Witness Signature: _____ Witness Printed Name: _____

Date: _____