



Client Enrolment Form

ALL INFORMATION WILL BE TREATED IN THE STRICTEST OF CONFIDENCE

PERSONAL DETAILS:

NAME:

ADDRESS:

CONTACT TELEPHONE NUMBERS:

EMAIL ADDRESS:

SEX:

Male Female

DATE OF BIRTH:

OCCUPATION:

SPORTS, HOBBIES:

EMERGENCY CONTACT DETAILS:

NAME:

CONTACT TELEPHONE NUMBERS:

EMAIL ADDRESS:

PART 1 – YOUR BACKGROUND AND YOUR HEALTH

1. DOES YOUR WORK/SPORT INVOLVE ANY OF THE FOLLOWING?

- | | |
|---|--|
| <input type="checkbox"/> Sitting for long periods | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Lifting heavy weights | <input type="checkbox"/> Any other repetitive action |

2. WILL THIS BE THE FIRST TIME THAT YOU HAVE PRACTISED PILATES?

- Yes No

If NO, have you previously attended:

- Studio
 Body Control Pilates Matwork classes
 Other Pilates matwork
 At home (book, DVD)

Number of classes attended previously:

- 0-5 5-10 10-20 20+

3. HAS YOUR DOCTOR EVER SAID THAT YOU HAVE ANY SORT OF HEART TROUBLE OR DEFECT?

- Yes No

4. DO YOU FEEL PAIN IN YOUR CHEST WHEN YOU UNDERTAKE PHYSICAL ACTIVITY?

- Yes No

5. ARE YOU, OR COULD YOU BE PREGNANT NOW?

- Yes No

If YES, when is your due date?

6. HAVE YOU BEEN PREGNANT IN THE LAST SIX MONTHS?

- Yes No

7. IF YOU HAVE HAD A BABY, HOW WAS IT DELIVERED?

- Vaginal
 Caesarean
 Vaginal with intervention (eg. Forceps)

8. DO YOU OFTEN GET HEADACHES?

Yes No

9. DO YOU LOSE YOUR BALANCE BECAUSE OF DIZZINESS OR DO YOU EVER LOSE CONSCIOUSNESS, FEEL FAINT OR DIZZY?

Yes No

10. DO YOU HAVE HIGH BLOOD PRESSURE?

Yes No

If YES, is this regulated by medication? Please give details:

11. IS YOUR BLOOD PRESSURE:

Normal Low

12. HAVE YOU HAD MAJOR SURGERY IN THE LAST 10 YEARS?

Yes No

13. HAVE YOU HAD MINOR SURGERY IN THE LAST TWO YEARS?

Yes No

14. DO YOU SUFFER FROM ASTHMA, DIABETES OR EPILEPSY?

Yes No

15. HAVE YOU EVER BEEN TOLD YOU HAVE ARTHRITIC JOINTS, OSTEOPOROSIS, OSTEOPENIA OR ANY BONE OR JOINT PROBLEM THAT MAY BE MADE WORSE BY EXERCISING?

Yes No

16. DO YOU SUFFER FROM BACK OR NECK PAIN?

Yes No

17. DO YOU HAVE PAIN OR RESTRICTED MOVEMENT IN ANY OTHER JOINTS (EG: HIP, KNEE, ANKLE, SHOULDER)?

Yes No

18. HAVE YOU EVER BEEN DIAGNOSED AS HYPERMOBILE (EXCESSIVE JOINT MOBILITY)?

Yes No

19. IF YOU HAVE ANSWERED 'YES' FOR QUESTIONS 14-18, DO YOU HAVE MEDICAL PERMISSION TO EXERCISE?

Yes No

20. ARE THERE ANY MOVEMENTS THAT CAUSE YOU PAIN?

Yes No

21. ARE YOU TAKING ANY DRUGS OR MEDICATION WHICH MAY AFFECT YOUR ABILITY TO EXERCISE?

Yes No

22. HAVE YOU EVER BEEN RECOMMENDED TO TAKE UP PILATES BY A SPECIALIST PRACTITIONER?

Yes No

If YES, by your:

- GP
- Physiotherapist
- Chiropractor
- Osteopath
- Other

23. DO YOU HEREBY GIVE US PERMISSION TO CONTACT THEM?

Yes No

If YES, please state their name and contact number:

Practitioner's name:

Practice telephone:

Please list any health problems you suffer, not already mentioned, that may affect your ability to exercise. If you have answered YES to any of questions 3-21 above, we advise you consult with your medical practitioner before you start Pilates Classes. Please give further relevant details below, in confidence, to any questions you ticked YES.

Are there any factors your teacher should be aware of that may prevent you from regularly attending classes (such as child care, lack of transport, shift work)?

PART 2 – YOUR AIMS

24. WHAT ARE YOUR REASONS FOR TAKING UP PILATES?

25. WHAT HEALTH OR PHYSICAL GOALS WOULD YOU LIKE TO ACHIEVE OVER THE NEXT THREE MONTHS?

26. WHAT LONGER-TERM HEALTH OR PHYSICAL GOALS WOULD YOU LIKE TO ACHIEVE OVER THE NEXT 12 MONTHS?

PART 3 – IMPORTANT INFORMATION

Please advise us before commencing any session if, for any reason, your health or your ability to exercise changes.

It is inadvisable to do Pilates between weeks 8 to 14 of pregnancy, unless by special arrangement with your teacher. It is also wise to wait six weeks after the birth before resuming exercise.

Pilates exercises are very safe but, as with all forms of physical exercise, it is prudent to consult your doctor before starting Pilates sessions.

These sessions are not a substitute for medical counselling or treatment. If you have any doubts about the suitability of the exercises, you should refer back to your medical practitioner. The teacher can accept no liability for personal injury related to participation in a session if:

- Your doctor has, on health grounds, advised you against such exercise
- You fail to observe instructions on safety or technique
- Such injury is caused by the negligence of another participant in the class/studio

Exercise should be performed at a pace which feels comfortable for you. Pain is the body's warning system and should not be ignored. Please inform your teacher immediately if you feel any discomfort during a session. Please also inform your teacher if you felt any discomfort after a previous session.

I understand that Body Control Pilates exercises involve hands-on correction and I hereby consent for my teachers to work in this way.

I confirm that I have read and understood the above advice and that the information I have given is correct.

I confirm that my teacher may use the contents of this form, and any other information I may later provide, for teaching purposes, and that this information:

- will be used in confidence and stored securely
- will not, in any circumstances, be shared with a third party without my written consent, unless that party is another (Body Control) Pilates teacher who will teach me.
- may be retained by the teacher for a period of time such as complies with professional, legal and insurance requirements that they must fulfil

I confirm agreement for my teacher to contact me with information on classes and other Pilates-related activities, and understand that I have the right to withdraw this 'consent to be contacted' at any time.

Signed:

Client..... Date.....

Teacher Date.....



This form is only to be used by certified Body Control Pilates teachers

