Metamorphosis Pilates & Bodywork
268 Main St, Second Floor
East Aurora, NY 14052
(716)239-7995

Date: _____

Pilates Client Information Form

Personal Information

Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: (cell) _____

(home) _____ email: _____

How would you like to be contacted: (Please check) Email [ ] Text [ ] Phone [ ]

In case of emergency: _____ Phone: _____

How did you hear about our studio? Who referred you to us? _____

Medical Information and History

**Please select Yes or No and explain Yes answers on back of this form:*

1) History of heart problems, chest pain or stroke ..... Yes [ ] No [ ]
2) Increased blood pressure ..... Yes [ ] No [ ]
3) Is your doctor currently prescribing anything for blood pressure or heart condition ..... Yes [ ] No [ ]
4) Any chronic illness or condition ..... Yes [ ] No [ ]
5) Difficulty with physical exercise ..... Yes [ ] No [ ]
6) Advice from physician not to exercise ..... Yes [ ] No [ ]
7) Recent surgery (last 12 months) ..... Yes [ ] No [ ]
8) Pregnancy (now or within the last 3 months) ..... Yes [ ] No [ ]
9) History of breathing or lung problems ..... Yes [ ] No [ ]
10) Muscle, joint or back disorder or any previous injury still affecting you ..... Yes [ ] No [ ]
11) Do you know of any other reason why you should not do physical activity ..... Yes [ ] No [ ]

List regular exercise or any past Pilates training:

_____

Are you presently doing other kinds of therapy? i.e. massage, physical therapy,chiropractic:

_____

What is your occupation? What does your typical day involve physically? i.e. sitting, lifting:

_____

What are your goals? What do you want most from this program:

_____

I, the undersigned applicant, for an in consideration of the benefit to be derived by participation in Metamorphosis Pilates program release its agents, representatives, and staff from any and all liability and responsibility for injury, illness, sickness or death which may result from participation in the Pilates classes or programs elected, and do hereby further agree to indemnify and hold Metamorphosis Pilates & Bodywork, its agents, representatives and employees from any and all liabilities in such regard

Applicant's Signature: _____ Date: _____

We appreciate your business!

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Policy Form

- Pilates sessions are 50 minutes in length
- All sessions must be cancelled within 24 hours to avoid being charged
- All packages are non-refundable and non-transferable and expire within 6 months
- For a guaranteed weekly time slot(s), a package should be purchased. If not, we require a credit card number on file
- Weekly appointment slots may be lost after three missed appointments
- Sessions dates / times are subject to change with minimum 24 hours advanced notice

Studio Etiquette

- Please refrain from use of heavy perfumes within studio for consideration of allergies sensitive clients and/ or instructors
- Please refrain from eating or chewing gum for safety consideration during session
- Please refrain from wearing clothes with zippers for consideration of equipment quality
- Children are welcome in the studio during session time if necessary, however we request that the child not play on or near the equipment for safety consideration

I understand and acknowledge the policies of Metamorphosis Pilates & Bodywork, Inc.

_____
Printed Client Name

_____
Signed Client Name

_____
Date

Client Information

Name _____ Phone (_____) _____ DOB _____

Address _____ City _____ State _____ Zip _____

E-mail: _____

Referred by: _____ Phone (_____) _____

In case of emergency: _____ Phone (_____) _____

Occupation _____ ❑ Male ❑ Female Physician _____

Health Insurance Carrier _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session? ❑ Yes ❑ No How recently? _____

What are your massage or bodywork goals? _____

What kind of pressure do you prefer? ❑ light ❑ medium ❑ firm

If you answer "yes" to any of the following questions, please explain as clearly as possible.

❑ Yes ❑ No Do you frequently suffer from stress?
❑ Yes ❑ No Do you have diabetes?
❑ Yes ❑ No Do you experience frequent headaches?
❑ Yes ❑ No Are you pregnant?
❑ Yes ❑ No Do you suffer from arthritis?
❑ Yes ❑ No Are you wearing contact lenses?
❑ Yes ❑ No Are you wearing dentures?
❑ Yes ❑ No Do you have high blood pressure?
❑ Yes ❑ No Are you taking high blood pressure medication?
❑ Yes ❑ No Do you suffer from epilepsy or seizures?
❑ Yes ❑ No Do you suffer from joint swelling?
❑ Yes ❑ No Do you have varicose veins?
❑ Yes ❑ No Do you have any contagious diseases?
❑ Yes ❑ No Do you have osteoporosis?
❑ Yes ❑ No Do you have any allergies?

❑ Yes ❑ No Do you bruise easily?
❑ Yes ❑ No Any broken bones in the past two years?
❑ Yes ❑ No Any injuries in the past two years?
❑ Yes ❑ No Do you have tension or soreness in a specific area?
Please specify _____
_____
❑ Yes ❑ No Do you have cardiac or circulatory problems?
❑ Yes ❑ No Do you suffer from back pain?
❑ Yes ❑ No Do you have numbness or stabbing pains?
❑ Yes ❑ No Are you sensitive to touch or pressure in any area?
❑ Yes ❑ No Have you ever had surgery? Explain below.
❑ Yes ❑ No Other medical condition, or are you taking any medications I should know about?

Comments _____
_____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/ bodywork should not be performed under certain medical conditions. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____