

## Client Enrolment Form

All information will be treated in the strictest of confidence.

Personal Details	
Name _____	Date of Birth _____
Address _____	Occupation _____
_____	Sports, Hobbies _____
_____ Postcode _____	
Contact Tel _____	
Mobile _____	
Email _____	
Sex: Male / Female	
	Emergency Contact Details
	Name _____
	Contact Tel _____
	Mobile _____

### PART 1: Your Background and Your Health

- Does your work/sport involve any of the following?  
(please tick)
 

<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
- Will this be the first time that you have practised Pilates?
 

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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 If NO, have you previously attended: (please tick)
 

<input type="checkbox"/> Studio	<input type="checkbox"/> Body Control Pilates matwork classes
<input type="checkbox"/> Other Pilates matwork	<input type="checkbox"/> At home (book, DVD)

 Number of classes attended:
 

<input type="checkbox"/> 0 - 5	<input type="checkbox"/> 5 - 10	<input type="checkbox"/> 10 - 20	<input type="checkbox"/> 20 +
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- Has your doctor ever said that you have any sort of heart trouble or defect?
 

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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- Do you feel pain in your chest when you undertake physical activity?
 

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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- Are you, or could you be, pregnant now?
 

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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 If YES, when is your due date? \_\_\_\_\_
- Have you been pregnant in the last six months?
 

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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- If you have had a baby, how was it delivered?
 

<input type="checkbox"/> normally	<input type="checkbox"/> caesarian
<input type="checkbox"/> normally with intervention (e.g. forceps)	
- Do you often get headaches?
 

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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- Do you lose your balance because of dizziness or do you ever lose consciousness, feel faint or dizzy?
 

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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- Do you have high blood pressure?
 

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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*please turn over*

## Client Enrolment Form

### PART 1: Your Background and Your Health (continued)

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 that 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 (e.g. hip, knee, ankle, shoulder)?

- Yes                               No

18. Have you been diagnosed as hypermobile (excessive joint mobility)?

- Yes                               No

19. Are there any movements that cause you pain?

- Yes                               No

20. Are you taking any drugs or medication which may affect your ability to exercise?

- Yes                               No

21. Have you been recommended to take up Pilates by a specialist practitioner?

- Yes                               No

If YES, by your:

- GP                               Physiotherapist  
 Chiropractor               Osteopath  
 Other \_\_\_\_\_

22. 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 that you consult with your medical practitioner before you start Pilates classes. Please give below further relevant details, in confidence, to any questions ticked YES.

## Client Enrolment Form

### PART 2: Your Aims

What are your reasons for taking up Pilates?

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What health or physical goals would you like to achieve over the next three months?

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What longer-term health or physical goals would you like to achieve over the next 12 months?

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### 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 the 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.

Signed,

Client \_\_\_\_\_

Date \_\_\_\_\_

Teacher \_\_\_\_\_

Date \_\_\_\_\_