



PERSONAL INFORMATION SHEET

Today's Date: _____

Personal Information

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth Date: ____/____/____

Contact Information:

Home phone: () _____

Cell phone: () _____

Work phone: () _____ Ext. _____

Email address: _____

Emergency Contact

Name: _____ Relationship: _____

Phone: () _____ Alternate phone: () _____

Employment Information

Occupation: _____

Employer: _____



Cancellation Policy

Clients who wish to cancel an appointment must notify our desk staff via phone at LEAST 24 hours before the scheduled appointment, and provide the reason(s) for cancellation.

You WILL be charged in full for all cancellations made within the 24 hours prior to the scheduled appointment.

I, _____, am aware that if I do not cancel my appointment 24 hours prior to the scheduled appointment, I will be responsible for 100% of the payment for the session.

Client Signature: _____ Date: _____

Additional Information

How did you find out about us? (Please check all that apply)

Friend Internet Magazine Newspaper Other: _____

May we send you notices about events, specials, etc? Yes No

Interests and Hobbies: (Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Aerobics | <input type="checkbox"/> Spinning |
| <input type="checkbox"/> Back Care classes | <input type="checkbox"/> Triathalons |
| <input type="checkbox"/> Courses | <input type="checkbox"/> Weight Lifting |
| <input type="checkbox"/> Gyrotonic | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Workshops |
| <input type="checkbox"/> Meditation | <input type="checkbox"/> Yoga |
| <input type="checkbox"/> Pilates | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Pre – Post natal classes | <input type="checkbox"/> Other: _____ |



Release and Waiver

I, _____ voluntarily desire to participate in physical and /or rehabilitation exercise training classes conducted by Mindful Movement and Physical Therapy and understand and agree with the following:

1. I assume full responsibility while voluntarily participating in any training or classes at my sole risk and shall abide by any and all rules and regulations for use of the facility which may be promulgated from time to time by Mindful Movement and Physical Therapy.
2. I am aware that there exists the possibility of certain conditions occurring during or following training and/or exercise. These conditions include, but are not limited to: mild or light headedness, fainting, abnormalities of blood pressure or heart rate, ineffective heart function and in rare instances, heart attack and stroke. The reaction of the cardiovascular system to such activity cannot be predicted with complete accuracy.
3. It is strongly recommended that I receive medical clearance from my private physician prior to starting this or any other exercise training program. This program can be designed for persons with known heart disease or those with disorders that require medical supervision; however those persons should have a direct physician referral. Mindful Movement and Physical Therapy reserves the right to deny services to those without their physicians' written consent or referral.
4. I expressly agree that I have been informed that the program involves possible risks and all exercises shall be undertaken at my sole risk and that Mindful Movement and Physical Therapy shall not be held liable to me or any other person, for claims, demands, injuries, damages, or causes of action, whatsoever, to my person or property arising out of or connected to services and/or exercises having direct relation to this facility. I do hereby release and discharge Mindful Movement and Physical Therapy thereof from all claims, demands, injuries, damages, actions or causes of action and from all acts of active or passive negligence on the part of Mindful Movement and Physical Therapy.

I HAVE READ THE ABOVE STATEMENT AND UNDERSTAND AND AGREE TO THE ABOVE CONDITIONS

Client's Signature: _____ Date: _____

Witness: _____ Date: _____



PLEASE FILL OUT THIS FORM TO THE BEST OF YOUR ABILITIES AND SIGN THE STATEMENT AT THE BOTTOM OF THE FORM. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK.

Last Name: _____ First Name: _____

Sex: _____ Age: _____ Marital Status: _____

Hobbies/Recreational activities and frequency: _____

Previous experience with Pilates/GYROTONIC: _____

General health (Check): _____ Excellent _____ Good _____ Fair _____ Poor

Personal fitness goals: _____

Are you currently experiencing any physical problems? If so, please explain: _____

Medications: _____

Previous Injuries: _____

Previous surgeries: _____

Are you currently receiving professional health care services (i.e. Chiropractic, Medical, Massage Therapy, Physical Therapy, etc...) _____



Are you currently or have you previously been diagnosed with any of the following? (Please check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pregnancy (currently) |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Bowel/Bladder Changes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shoulder Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Stenosis |
| <input type="checkbox"/> Circulatory Disease | <input type="checkbox"/> Hyperglycemia | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Numbness or Weakness | <input type="checkbox"/> Osteopenia |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Fainting Disorder | <input type="checkbox"/> Heart Disease | |

Other: _____

Is there anything else that you feel we should know about or have not asked? If so, please explain: _____

I, THE UNDERSIGNED, DO HEREBY CERTIFY THAT I HAVE COMPLETED THE ABOVE INFORMATION AND KNOW IT TO BE TRUTHFUL AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature: _____ Date: _____