302 W. Main St. Suite 204
Avon, CT 06001
860-679-0430 Phone
860-679-0431 Fax

PILATES STUDENT INFORMATION

Date of first session: ____________ Class time: __________

Name: ____ Date of Birth: ____________________

Address: _______________________________________City:_________________Zip:___________

Home Phone: __________________ Business: _______________ Cell Phone: _________________

E-Mail Address: ____ Marital Status: M S

Occupation: _____________________________

Emergency Contact: _______________________________________Phone:____________________

Primary Care MD: ____Phone:____________________

Specialist MD: ____Phone:____________________

How did you hear about Magna Physical Therapy & Golf Medicine Center? _____________________

Are you interested in information about our Personal Training programs? Yes No

Would you like information about becoming a Power Pilates instructor? Yes No

Have you taken Pilates classes previously? Yes No

All of the above information is correct to the best of my knowledge:

Client/Guardian/SIGNATURE: ____________________________________ **Date**:_______________

STUDIO POLICIES

- Classes are paid for in groups of 12 sessions or as single sessions. Your 12 sessions must be completed within six months of the purchase date (e.g. if you pay on January 1st, the remaining sessions will expire on July 1st). If extenuating circumstances prevent you from using all of your sessions within six months, please let your instructor know and we will make a mutually acceptable arrangement.
- It is our policy that services be paid for at the time of or before services are rendered.
- In an effort to keep costs low, ***Magna Physical Therapy*** does not accept credit or debit cards. Payments must be made by cash or check.
- In the case that you are not able to attend a Pilates session that you normally would attend, we ask that you call our office and let us know.

I, the undersigned, have reviewed the above policies and do hereby agree to abide by them to the best of my abilities.

Client/Guardian/SIGNATURE: ____________________________________
Date:_______________

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MEDICAL HISTORY FORM

Name:____

Do you experience or has a physician told you that you have:

	Circle One			Circle One	
High Blood Pressure	Y	N	Traumatic Brain Injury	Y	N
High Cholesterol	Y	N	Phlebitis	Y	N
Diabetes	Y	N	Anemia	Y	N
Previous / Current Smoker	Y	N	Asthma	Y	N
Family History/ Heart Disease	Y	N	Shortness of Breath	Y	N
Cardiac Arrhythmia	Y	N	Currently Pregnant?	Y	N
Heart Disease	Y	N	Allergies	Y	N
Coronary Artery Disease	Y	N	Emphysema	Y	N
Heart Murmur	Y	N	Headache/Dizziness	Y	N
Heart Surgery	Y	N	Kidney Disease	Y	N
Congestive Heart Failure	Y	N	Osteoporosis	Y	N
Angina/Chest Pain	Y	N	Cancer	Y	N
Stroke	Y	N	Hernia	Y	N
Claudication/PVD	Y	N	Liver Disease	Y	N
Seizures	Y	N	Psychological Disorders	Y	N
Parkinson's Disease	Y	N	Multiple Sclerosis	Y	N
Gout	Y	N	Arthritis	Y	N
Joint Disease	Y	N	Swollen Feet/Ankles	Y	N
Fractured Bones	Y	N	Hearing Problems	Y	N
Vision Problems	Y	N	Sensory Problems	Y	N
Back Pain	Y	N	Neck Pain	Y	N
Knee Pain	Y	N			

Please make any necessary comments about the above:
____
____
____

Do you currently exercise?
If so, how many times per week? ________
How long per session? ________
What type(s) of exercise? ________

Current Medications
____
____
____

Please List any Surgeries you have had:
1.________________ Date:____________Surgeon:_____________
2.________________ Date:____________Surgeon:_____________

*Client/Patient/Guardian Signature:*___________________________________ *Date:*________________

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EXERCISE CONSENT FORM

I wish to join/be treated by Magna Physical Therapy & Sports Medicine Center, LLC to improve my fitness level/receive physical therapy. Before entering the program I understand that I will need to complete a medical history form for the purpose of detecting any condition, which may indicate that I should not participate in a fitness program or that my program may need to be altered. I understand that withholding information about my health may result in an incorrect exercise prescription, which may cause harm to me. I understand that if I have certain pre-existing medical problems, or if concerns develop during the course of my health history, the staff will request information from my physician, and will request his/her consent for my participation. I understand the staff will review all data submitted and develop a safe and effective exercise program for me. All information received or generated about me is strictly confidential.

I understand that no assurance can be given to me that participation in a fitness program will increase my functional/athletic capacity, improve my blood sugar and blood pressure, assist in weight loss and tone my muscles; however current research indicates that improvement in these areas can be achieved with active participation in an exercise program. In addition, feelings of increased confidence and a sense of well being usually occur.

The exercises are designed to place a gradually increasing workload as tolerated on my cardiovascular and musculoskeletal system and thereby improve its functioning. The reaction of my body cannot be accurately predicted. I understand the risks associated with exercise include blood pressure abnormalities, lung congestion, irregular heartbeats, muscle pain and soreness, and in very rare instances a "heart attack", "stroke" or "cardiac arrest." I understand that the Magna Physical Therapy & Sports Medicine Center staff will take all measures to avoid such happenings. I understand that providing the staff with current information about changes in my health, which includes any illness or symptoms I experience in the performance center or at home, is essential for the Magna Physical Therapy & Sports Medicine Center staff to determine if any modifications need to be made in my exercise program. I understand that if I do not inform the Magna Physical Therapy & Sports Medicine Center staff that I may be putting myself at risk for injury or serious medical problems.

I understand that I am required to respect the rights of all participants and staff members involved with the Magna Physical Therapy & Sports Medicine Center. I understand that the staff has the right to address concerns about my health with my physician and may ask to temporarily discontinue my exercise program until my physician evaluates my condition and advises me on my return.

I acknowledge that no guarantees can be made to me as a result of my participation in the program. I hereby release Magna Physical Therapy & Sports Medicine Center, LLC, its affiliated entities, employees, trustees and their respective representatives and agents from all claims, liabilities, and causes of action arising or associated with my participation in this program. I have read the foregoing or it has been read to me, and I understand its contents and significance.

Client/Participant/Guardian **Signature**:____________________________**Date**:_______________

MPT&GMC Witness **Signature**:_________________________________**Date**_______________