CLIENT REGISTRATION FORM

Today's Date: ___ / ___ /_____ Your Name: _____

How did you hear about us or who referred you?

☐ Friend ☐ Former PT Patient ☐ Telephone Directory Ad ☐ Physician
☐ Newspaper ☐ Another Gym ☐ Other _____

Sex: ☐ Male ☐ Female Date of Birth: _____

Address: _____

_____

_____

Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____

In Emergency: _____ Phone: _____
Physician: _____ Phone: _____

CONTACT INFORMATION

Today's Date: ___ / ___ /_____ Name: _____

Please contact me via:

Check the box(es) that apply:

☐ E-Mail ☐ Home Number
☐ Cell Phone ☐ Text

Email address: _____
Home Phone: _____
Cell Phone: _____

Signature: _____ Date _____
Print Name: _____

CANCELLATION AND NO-SHOW POLICY

We strive to provide not simply good, but absolutely the best care to our clients. We schedule our clients according to care plans that optimize their wellness outcomes. Making your appointment as scheduled is very important, not just for us, but for you. We are convinced that if you make your wellness a life priority, you will achieve not only a higher level of function, but a greater degree of happiness.

Services and appointment times are in high demand. We attempt to schedule all new clients within 24-48 hours of their initial request for service. Thus, the appointment time is a valuable commodity for both parties.

If it is necessary to cancel a scheduled session, please call the office at least 24 hours in advance. If you call within 12 hours or less from the scheduled time or you do not show for your scheduled session, you will be charged for that visit. The missed session will be deducted from any package you have on account at the package price. If you pay individually, the single price for the missed session will be added to the payment of your next session.

While we are not fond of the negative connotation of any cancellation policy, we believe such a policy is in the best interest of accommodating all of our clients who are dedicated to improving their wellbeing. Thank you for your consideration.

By signing below, I understand and accept the above cancellation / no-show policy. I have read the above cancellation policy and agree to pay for any appointments cancelled less than 12 hours in advance.

Signature _____ Date _____

Print Name _____

Witness _____ Date _____

Print Name _____

WAIVER AND RELEASE FROM LIABILITY AND INDEMNITY AGREEMENT

I, the undersigned, hereby request permission to use the facilities owned and operated by KateSaid Fitness and Pilates Studio located at 722 Gittings Avenue, Peachtree City, Georgia. I know the risks and dangers in using said facilities and all equipment currently on the premises or on the premises in the future and in participating in such activities, and that unanticipated and unexpected dangers may arise during the use of said facilities and equipment and during the participation in said activities, and I ASSUME ALL RISKS OF INJURY TO MY PERSON, INCLUDING DEATH, AND TO MY PROPERTY that may be sustained in connection with the stated and associated activities.

In consideration for being permitted to use the facilities and equipment of KateSaid Fitness and Pilates Studio, I agree, in addition to paying for the services rendered, to release KateSaid Fitness and Pilates Studio, its instructors, operators, owners, servants, agents, officials, officers and sponsors from all claims from liability, demands, actions, and causes of actions of any sort made by myself, my heirs, administrators, executors, guardians, and/or assigns arising out of injury to my person or out of my death or injury to my property, whether caused by the negligence of KateSaid Fitness and Pilates Studio, its instructors, operators, owners, servants, agents, officials, officers or sponsors while I am using its facilities or equipment or participating in other activities sponsored by KateSaid Fitness and Pilates Studio on or off its premises.

I also agree to indemnify and hold harmless KateSaid Fitness and Pilates Studio, its instructors, operators, owners, servants, agents, officers, officials, and sponsors, for any loss, liability, damage or cost they may incur due to my presence on the premises of KateSaid Fitness and Pilates Studio whether caused by the negligence of KateSaid Fitness and Pilates Studio, its instructors, operators, owners, servants, agents, officers, officials or sponsors or otherwise.

I represent and certify that my true age is years and I am over the age of eighteen (18) years.

(OR)

I represent and certify that my child is years of age and I, as parent or legal guardian, consent to and authorize my child's participation in the above stated activities and I have full knowledge thereof and, as parent or legal guardian, knowingly and voluntarily executed this Waiver and Release form Liability and Indemnity Agreement.

I certify that my attendance and participation in the stated activities are voluntary.

IN WITNESS WHEREOF, I have executed this WAIVER AND RELEASE FROM LIABILITY AND INDEMNITY AGREEMENT ON:

Signature _____ Date _____

Print Name _____

Witness _____ Date _____

Print Name _____

MEDICAL SCREENING QUESTIONNAIRE

NAME: _____ LEISURE ACTIVITIES: _____
OCCUPATION: _____

ALLERGIES: List any medication(s) you are allergic to: _____
Are you latex sensitive? ☐ YES ☐ NO List any other allergies we should know about _____
_____
Have you declared the Advanced Clinical Directive of Do Not Resuscitate? ☐ YES ☐ NO

Please check (**X**) any of the following whose care you're under

_____ Medical doctor (MD) _____ Psychiatrist/Psychologist _____ Other
_____ Osteopath _____ Physical Therapist
_____ Dentist _____ Chiropractor

If **YOU** have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.): _____
_____

Have **YOU** ever been diagnosed as having any of the following conditions?

☐ YES ☐ NO Cancer. If YES, describe what kind:
_____
☐ YES ☐ NO Heart Problems
☐ YES ☐ NO High blood pressure
☐ YES ☐ NO Circulation problems
☐ YES ☐ NO Asthma
☐ YES ☐ NO Emphysema/Bronchitis
☐ YES ☐ NO Chemical dependency (i.e. alcohol, drugs)
☐ YES ☐ NO Thyroid problems
☐ YES ☐ NO Diabetes
☐ YES ☐ NO Multiple sclerosis

☐ YES ☐ NO Rheumatoid arthritis
☐ YES ☐ NO Other arthritic conditions
☐ YES ☐ NO Depression
☐ YES ☐ NO Hepatitis
☐ YES ☐ NO Tuberculosis
☐ YES ☐ NO Stroke
☐ YES ☐ NO Kidney disease
☐ YES ☐ NO Anemia
☐ YES ☐ NO Epilepsy
☐ YES ☐ NO Osteoporosis/Osteopenia
☐ YES ☐ NO Other _____

During the past month have you been feeling down, depressed or hopeless? ☐ YES ☐ NO
During the past month have you been bothered by having little interest or pleasure in doing things? ☐ YES ☐ NO
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ☐ YES ☐ NO

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

	DATE	REASON FOR SURGERY/HOSPITILIZATION
1.	_____	_____
2.	_____	_____
3.	_____	_____

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

DATE	INJURY	DATE	INJURY
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL SCREENING QUESTIONNAIRE

kateSaid FITNESS

Has anyone in your **IMMEDIATE FAMILY** (parents, brothers, sisters) ever been treated for any of the following?

- ☐ YES ☐ NO Diabetes
- ☐ YES ☐ NO Tuberculosis
- ☐ YES ☐ NO Heart disease
- ☐ YES ☐ NO High blood pressure
- ☐ YES ☐ NO Stroke
- ☐ YES ☐ NO Kidney disease
- ☐ YES ☐ NO Alcoholism (chemical dependency)
- ☐ YES ☐ NO Cancer
- ☐ YES ☐ NO Arthritis
- ☐ YES ☐ NO Anemia
- ☐ YES ☐ NO Headaches
- ☐ YES ☐ NO Epilepsy
- ☐ YES ☐ NO Mental Illness

Which of the following **OTC (OVER-THE-COUNTER)** medications have you taken in the last week?

- ☐ YES ☐ NO Aspirin
- ☐ YES ☐ NO Tylenol
- ☐ YES ☐ NO Advil/Motrin/Ibuprofen
- ☐ YES ☐ NO Laxatives
- ☐ YES ☐ NO Decongestants
- ☐ YES ☐ NO Antihistamines
- ☐ YES ☐ NO Antacid
- ☐ YES ☐ NO Vitamins/mineral supplements
- ☐ YES ☐ NO Herbs
- ☐ YES ☐ NO Other _____

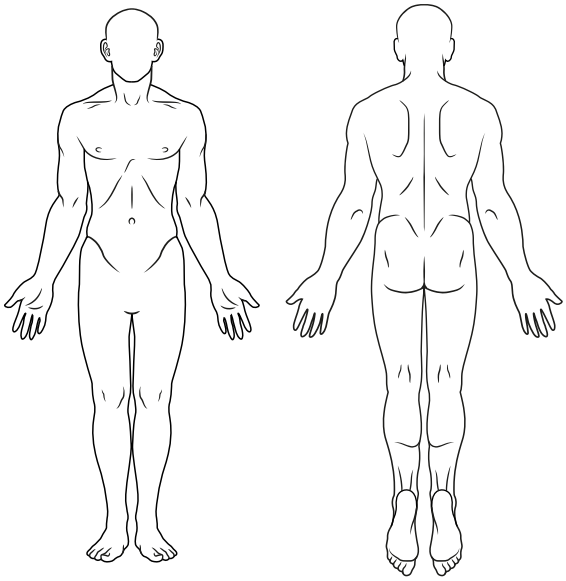
How much caffeinated coffee or caffeine containing beverages do you drink per day? _____
How many packs of cigarettes do you smoke a day? _____
How many days per week do you drink alcohol? _____
If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____

Have you recently noted:

- ☐ YES ☐ NO Weight loss/gain
- ☐ YES ☐ NO nausea/vomiting
- ☐ YES ☐ NO fatigue
- ☐ YES ☐ NO weakness
- ☐ YES ☐ NO fever/chills/sweats
- ☐ YES ☐ NO numbness or tingling

On a scale from 0 to 10- rate your pain: Best: _____ Worst: _____ Current: _____

Please mark below on the diagram where your pain is:



MEDICAL SCREENING QUESTIONNAIRE

Describe the type of pain you are experiencing (ache, burning, dull, pulsing, sharp, stabbing, steady, throbbing, shooting, other): _____

_____

When did you first experience your pain? Month/Year _____

What activities alleviate your pain? _____

_____

_____

What activities aggravate your pain? _____

_____

_____

Has your condition been getting better or worse? ☐ BETTER ☐ WORSE (If WORSE, describe below)

_____

_____

Are you currently participating in a regular exercise routine? ☐ YES ☐ NO (If YES, describe below)

_____

_____

CLIENT/GUARDIAN:

Signature: _____

Print Name: _____

Date: _____

PILATES INSTRUCTOR:

Signature: _____

Print Name: _____

Date: _____