

Full Name:

Address:

Email: ­­

Contact Number: DOB:

Emergency Contact: Relationship:   
Contact number:

How did you hear about us?

**Client waver and medical information (Please circle)**

Have you participated in Reformer Pilates before? YES NO

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| --- | --- |
| Are you Pregnant? | YES NO |
| Have you given birth in the past 12-18 months?  If yes, how many week pp are you? | YES NO |
| Did you deliver via caesarean section? | YES NO |
| Have you consulted a Pelvic health specialist or GP to be cleared to exercise? | YES NO |
| Do you have any abdominal separation? | YES NO |
| Do you suffer from an symptoms of prolapse, a weak pelvic floor or incontinence? | YES NO |
| Do you have any pain or discomfort when lying on your stomach? | YES NO |
| Do you have any pain or discomfort when lying on your back? | YES NO |
| Do you have any injuries that your instructor needs to aware of? | YES NO |
| Have you had any recent surgeries? | YES NO |
| Have you ever been told that you have a heart condition or have you ever suffered a stroke? | YES NO |
| Do you ever have any unexplained chest pain or discomfort at rest or during exercise? | YES NO |
| Do you ever feel faint, dizzy or struggle with balance during exercise? | YES NO |
| Have you had an asthma attack that required immediate medical attention in the last 12 months? | YES NO |
| If you have diabetes, have you experience trouble with maintaining you blood sugar at any time in the last 3 months? | YES NO |
| Do you have any other conditions that may need extra consideration when participating in a class? | YES NO |
| Is there any other information that we need to be aware of? |  |

PLEASE NOTE:

* If you are pregnant, we highly recommend medical clearance to participate and not starting a new exercise program that you weren’t participating in prior to pregnancy. After 22 weeks, we require medical clearance from either your GP or medical team to continue and participation is limited to private or Mums n bubs classes. If you wish to continue after 36 weeks, you will be require to have a private or 1 on 2 class.
* If you answered yes to any form of pain or are recovering from surgery, we require medical clearance from your doctor or specialist to begin or continue classes.
* PLEASE LET YOUR INSTRUCTOR KNOW IF YOU **DO NOT CONSENT** TO BEING INCLUDED IN PHOTOGRAPHS OR VIDEO FOOTAGE THAT MAY BE USED FOR SOCIAL MEDIA PURPOSES

I ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ declare that I have read the medical questionnaire and completed it honestly and truthfully to the best of my knowledge. I understand and agree that I am responsible for my own capabilities and will notify my instructor if I experience any pain or discomfort during the class. I understand that if the instructor feels that I am unfit to partake in the workout, they may ask that I discontinue. The program of exercises is to be undertaken in a supervised reformer Pilates class only.

I understand that if I choose to perform any of these exercises unsupervised and outside of the class, I do this at my own risk.

CLIENT NAME: DATE:

CLIENT SIGNATURE:

INSTRUCTOR SIGNATURE: DATE: