



Moving Moxie Pilates Studio, LLC
1515 SW Sunset Blvd.
Portland, OR 97239
ph. (503)244-1240
kenziepetterson@gmail.com

CONTACT

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Yes, you can email information about Health & Pilates No, I would prefer you not contact me by email

Occupation: _____ Year of Birth: _____

How did you learn about our services? _____

Emergency Contact: _____ Phone: _____

HISTORY

Have you participated in PILATES exercises before? YES NO If yes, how long?

What are your goals for your PILATES experience? Muscle Tone Weight Reduction Flexibility General Health

Other: _____

What other type of movement exercise or sports have you participated in before?

_____ Do you currently have any current injuries, pain or soreness? YES NO If yes, Please describe:

Are you currently under medical or therapeutic treatment? YES NO If yes, Please explain:

Please list any Current Medications:

Do you have any friends or family who might like to learn about our Pilates Programs?: Name / contact info?

Contact:

Contact:

For future reference, what days / times for classes would be best for your schedule?:

Any other information that may be helpful?

Medical History

Please check the following conditions that apply to your, past and present.

Musculo-Skeletal	Circulatory and Respiratory	Skin
<input type="checkbox"/> Spinal Injuries or degeneration	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Allergies
<input type="checkbox"/> Joint Stiffness/Swelling	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Other:
<input type="checkbox"/> Spasms/Cramps	<input type="checkbox"/> Fainting	
<input type="checkbox"/> Jaw pain/TMJ	<input type="checkbox"/> Cold hands or feet	
<input type="checkbox"/> Tendonitis or Bursitis		Other
<input type="checkbox"/> Stenosis	<input type="checkbox"/> Blood clots	<input type="checkbox"/> Hearing impaired
<input type="checkbox"/> Arthritis or Osteoporosis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Visually impaired
<input type="checkbox"/> Hip Replacement	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Bladder infection
<input type="checkbox"/> Bone or Joint Disease	<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Laminectomy	<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Scoliosis	- Stabilized with meds? - <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Cancer
<input type="checkbox"/> ACL or Knee Injury	<input type="checkbox"/> Other:	Infectious Disease <input type="checkbox"/> Please list: _____
Nervous System	Endocrine System	
<input type="checkbox"/> Headaches		Are you Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Surgeries: _____ _____ - Any other additional comments regarding your health and well being? _____ _____ _____
<input type="checkbox"/> Numb/Tingling	<input type="checkbox"/> Endometriosis	
<input type="checkbox"/> Twitching of face	<input type="checkbox"/> Prostate problems	
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Other:	
<input type="checkbox"/> Chronic pain	<input type="checkbox"/>	
<input type="checkbox"/> Epilepsy	<input type="checkbox"/>	
<input type="checkbox"/> Shingles		
<input type="checkbox"/> Other:	Digestive	
	<input type="checkbox"/> Nervous stomach	
	<input type="checkbox"/> Indigestion	
	<input type="checkbox"/> Crohns's Disease	
	<input type="checkbox"/> Other:	

Physician Name: _____ Phone: _____

I have noted all conditions that I am aware of and this information is accurate. I will inform my Pilates Teacher of any changes. Int: _____

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NOTE: If you have checked any above, or are under treatment for other medical conditions, please consult with your physician before starting classes.

Comments:

Client Signature: _____ Date: ____/____/____



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Waiver of Liability and Informed Consent Release

I, _____ wish to participate in the exercise and training program offered by MOVING MOXIE PILATES (MMP). I hereby certify that I have answered all health and medical questions honestly and completely and have no health issues that effect my ability to safely participate in the practice of Pilates. I further acknowledge that I will consult with my physician if I have any concerns about my safe participation in Pilates classes offered by Moving Moxie Pilates.

I understand that I am not obligated to perform or participate in any activity that I do not wish to do, and that it is my right to refuse participation at anytime during my training sessions for any reason.

I understand the results of my fitness program cannot be guaranteed and my progress depends on my effort and cooperation in and outside of the sessions.

I understand that if I arrive late, there is no guarantee that I will receive the full session time with my instructor, and that if I miss a class without 24 hour notice, there is no promise of a refund.

I understand that MMP bills clients on a pre-pay basis, and that once I have decided on the type of training plan to participate in, payment is due before sessions begin.

I understand that during a session Touch Training may be used to correct alignment and/or to focus my attention on a particular muscle area, and that if I am uncomfortable in any way with instructors touching me that I will notify them to discontinue this training element immediately.

I hereby authorize MMP and its instructors to act on my behalf in the event that I am a victim of an accident, sudden illness, or injury that occurs on the premises of MMP. Actions on my behalf shall include but not be limited to calling for emergency care, administering CPR, or seeking any help and advice they deem appropriate for medical care.

I agree that MMP and its instructors will not be liable or responsible for any injuries resulting from participation in their programs. I expressly release and discharge MMP and it's employees, investors, teachers, contractors, consultants, landlord, agents and or assigns from all claims, actions, judgments, and the like that I or my heirs, executors, administrators, or assigns my have or claim to have as a result of any injury or other damage which may occur in connection with my participation in the fitness program or my use of the facilities, including damages which are caused or alleged to be caused, in whole or in part, by the negligence of MMP or it's employees, investors, teachers, contractors, consultants, landlord, agents and or assigns, excepting only intentional acts of such person or persons.

I have thoroughly read this Waiver of Liability and Informed Consent Release and understand all of its terms. I sign this agreement voluntarily and with full knowledge of its significance.

Signed: _____ Date: ___ / ___ / _____

Printed Name: _____