Amato
chiropractic wellness center

Pilates Intake

Date _____

Name _____ Phone _____

Address _____ Birth Date _____

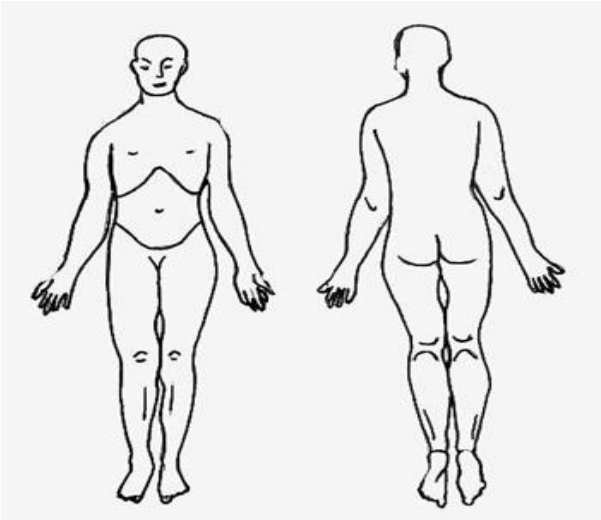
Emergency Contact/Relation _____ Phone _____

What is the reason for your initial visit for Pilates therapy? _____

_____

Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing.

Sharp and Stabbing = ++++ Numbness = //// Dull and Achy = VVVV
Pins and Needles = XXXX Places to Stretch = **** Places to tone/strengthen = OOOO



In the last year, do you currently or did you have any surgeries or injuries? (please explain)

_____

_____

Please list all medication you are currently taking, how much, and what they are for:

_____

_____

Please describe your diet and any vitamins/supplement intake:

_____

_____

Do you have any physical limitations? Lack of mobility, unable to roll over, joint restriction, etc...

_____

_____

What type of fitness do you practice? _____

_____

How do you manage stress? _____

_____

Do you have any of the following medical conditions that have been diagnosed by a physician?

____ Pregnancy, if yes how far along? _____

Physician's name and phone: _____

____ Allergies, please explain: _____

____ Diseases, if yes please explain: _____

____ Skin disorders, please explain: _____

____ Infections, please explain: _____

____ High/Low Blood pressure: _____

____ Heart conditions, please explain: _____

____ Breathing difficulties, please explain: _____

____ Blood clots, please explain: _____

____ Arthritis, describe areas of body affected: _____

____ Diabetes, Type 1 or Type 2 and what age of onset: _____

____ Cancer, please explain: _____

____ Other, please explain: _____

_____

Cancellation of a scheduled appointment /class must be made at least 24 hours in advance. If you are a self pay/package client, a charge equivalent to a session will be charged from your package. If your services are being billed to your insurance, then you would be responsible for the $30.00 cancellation fee. The fee is not covered by insurance. When canceling a Monday appointment, to avoid the fee, please cancel by the previous Friday during office hours. We do not receive answering machine messages until Monday morning.

1. Non-cancellation fees must be paid prior to your next appointment.
2. All unused classes expire 4 months after the date of first use.
3. Unused classes can only be put on hold if we are provided with proper medical documentation before your classes expire.
4. All sales are final. We cannot change a previously purchased package into another.
5. All class times, days, fees and instructors are subject to change.

The undersigned has read and acknowledges the above.

Signature: _____ Date: _____

Pilates Therapy Informed Consent

I have read and understood this client Intake and Health History form in its entirety. If at any time there are changes in the information given, or in my condition, I will notify the therapist and update this form before receiving additional sessions. I have stated all my known medical conditions and have answered all questions honestly. If there is any information not directly requested on this form, which would compromise my ability to safely participate in Pilates, I am responsible for bringing that information to the therapist's attention by noting it here:

_____

_____

The Pilates session I am requesting is for the purpose(s) of strengthening and stretching muscles, improving range of motion, facilitating better spinal alignment and posture, and to actively participate in my overall health and wellbeing.

I understand the Pilates therapist does not diagnose or prescribe for medical illness, disease, or other disorders. I further understand that Pilates therapy is not a substitute for medical examination or diagnosis, and that I take responsibility for consulting with my physician for any ailment or condition of concern to me. If I experience any pain or discomfort during the Pilates session, I will immediately communicate that to the therapist so that treatment may be adjusted accordingly.

I understand that my feedback is an essential element in my treatment. If at any time I become uncomfortable during the session, I may bring that to the therapist's attention and request that the session be modified, temporarily suspended, or brought to an end. However, I can ask that a session be discontinued at any time, for any reason, and the therapist will honor that request. I also understand that the therapist will help train my mind/body with mildly strenuous exercise and will also apply hands on technique as necessary.

I understand that if the Pilates therapist starts a session late, they will make it up to me at the end of my session if possible, or will reduce my fee accordingly. I understand that if I arrive late, my session will end at the originally scheduled time so the client following me is not penalized.

_____ _____

Client's Signature Date

_____ _____

Therapist's Signature Date