



Increase your well being with Polestar Pilates.

FITNESS INFORMATION SHEET

Today's Date: _____

Personal Information

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth Date: ____/____/____ Phone: _____

Employment Information

Occupation: _____

Employer: _____

Contact information

Work phone: () _____ Ext. _____

Home phone: () _____

Cell phone: () _____

Fax: () _____

Email address: _____

Emergency Contact

Name: _____ Relationship: _____

Phone: () _____ Alternate Phone: () _____

Additional Information

How did you find out about us? (check all that apply)

___ Friend ___ Internet ___ Magazine ___ Newspaper ___ Other: _____

May we send you notices about events, specials, etc? (check) ___ Yes ___ No

If yes, e-mail address: _____

Interests and Hobbies: (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Aerobics | <input type="checkbox"/> Spinning |
| <input type="checkbox"/> Back Care Classes | <input type="checkbox"/> Triathlons |
| <input type="checkbox"/> Courses | <input type="checkbox"/> Weight lifting |
| <input type="checkbox"/> GYROTONIC® | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Workshops |
| <input type="checkbox"/> Meditation | <input type="checkbox"/> Yoga |
| <input type="checkbox"/> Pilates | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Pre-Post natal classes | <input type="checkbox"/> Other: _____ |

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fitness



RELEASE AND WAIVER

I, _____ voluntarily desire to participate in physical and/or rehabilitation exercise training classes conducted by Polestar Physical Therapy and Pilates Center (hereinafter referred to as "Polestar") located at 1500 Monza Avenue, Suite 350, Coral Gables, Florida 33146 and understand and agree with the following:

1. I assume full responsibility while voluntarily participating in any training class at my sole risk and shall abide by any and all rules and regulations for use of the facility which may be promulgated from time to time by its owner or Polestar .
2. I am aware that there exists the possibility of certain conditions occurring during or following training and/or exercise. These conditions include, but are not limited to: mild or light-headedness, fainting, abnormalities of blood pressure or heart rate, ineffective heart function and in rare instances, heart attack and stroke. The reaction of the cardiovascular system to such activity cannot be predicted with complete accuracy.
3. It is strongly recommended that I receive medical clearance from my private physician prior to starting this or any exercise training program. This program can be designed for persons with known heart disease or those with disorders which require medical supervision however, those persons should have a direct physician referral. Polestar reserves the right to deny services to those without their physicians' written consent/referral.
4. I expressly agree that I have been informed that the program involves possible risks and all exercises shall be undertaken at my sole risk and that neither Polestar, nor the Officers, Directors, agents or employees shall be liable to me or any other person, for any claims, demands, injuries, damages, actions or causes of action, whatsoever, to my person or property arising out of or connected to services and/or exercises having direct relation to this facility. I do hereby release and discharge Polestar thereof from all claims, demands, injuries, damages, actions, or causes of action and from all acts of active or passive negligence on the part of Polestar or their officers, directors, agents or employees.

I HAVE READ THE ABOVE STATEMENT AND UNDERSTAND THE ABOVE CONDITIONS

Client's Signature: _____ Date: _____

Witness: _____ Date: _____

24 Hour Cancellation Policy

I am aware that if I do not cancel my physical therapy or training appointment before 3pm on the day previous to my appointment, I will be responsible for 50% of the payment for the session.

Client's Signature: _____ Date: _____



HEALTH SCREENING

PLEASE COMPLETE THIS FORM TO THE BEST OF YOUR ABILITIES AND SIGN THE STATEMENT AT THE BOTTOM OF THE FORM. IF YOU HAVE ANY QUESTIONS, PLEASE ASK.

Last Name: _____ First Name: _____

Sex: _____ Age: _____ Marital Status: _____

Hobbies/Recreational Activities and Frequency: _____

Previous Experience with Pilates/ GYROTONIC® _____

General Health (Check): ___Excellent ___Good ___Fair ___Poor

Personal Fitness Goals: _____

Are You Currently Experiencing Any Physical Problems? If So, Please Explain: _____

Medications: _____

Previous Injuries: _____

Previous Surgery: _____

Are You Currently Receiving Professional Health Care Services (i.e. Chiropractic, Medical, Massage Therapy, Physical Therapy, Etc...): _____

Are You Currently or Have You Previously Been Diagnosed with any of the Following (please check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pregnancy (currently) |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Bowel/Bladder Changes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shoulder Impingement |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Stenosis |
| <input type="checkbox"/> Circulatory Disease | <input type="checkbox"/> Hyperglycemia | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Numbness or Weakness | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Fainting Disorder | <input type="checkbox"/> Osteopenia | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoarthritis | |

Other: _____

Is There Anything Else That You Feel We Should Know About or Have Not Asked? If So, Please Explain: _____

I THE UNDERSIGNED, DO HEREBY CERTIFY THAT I HAVE COMPLETED THE ABOVE INFORMATION AND KNOW IT TO BE TRUTHFUL AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature: _____ Date: _____