PILATES 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: ___________________________

Email: _____________________________________

In Emergency: _________________________________ Phone: ______________________________

Physician: ____________________________________ Phone: ______________________________

We have a 24-hour cancellation policy. Clients are responsible for 100% of the cost of personal training or Pilates services for appointments cancelled less than 24-hours in advance. ProHealth recommends that you consult a physician prior to beginning any exercise program.

I have read the above cancellation policy and agree to pay for any appointments cancelled less than 24 hours in advance.

____ _________________________________
Signature Date

____
Witness

PROHEALTH Cancellation / 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.

We have the most highly trained and experienced clinicians in the region. You are working with the best. Their services and time are in high demand, with waiting lists for many of their services. As you know, we attempt to schedule all new clients within 24-48 hours of their initial request for service. Thus, appointment time is a valuable commodity for both you and us.

If negative circumstances require you to cancel a scheduled appointment, we request that you do so at least 48 hours in advance. If you must cancel within 24 hours of your appointment or fail to show up for your appointment, a $20 fee will be applied for therapy patients. For Pilates session clients, that visit will count toward your total session-package visits. For single visit clients, the client will be charged for a full visit.

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.

____

NAME DATE

1401 Georgian Park, Suite 120
Peachtree City, GA 30269

PROHEALTH
Physical Therapy and Pilates Studio

WAIVER AND RELEASE FROM LIABILITY AND INDEMNITY AGREEMENT

I, the undersigned, hereby request permission to use the facilities owned and operated by ProHealth Physical Therapy and Pilates Studio located at 1401 Georgian Park Drive, 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, ad 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 ProHealth Physical Therapy and Pilates Studio. I agree, in addition to paying for the services rendered, to **release ProHealth Physical Therapy and Pilates Studio**, its instructors, operators, owners, servants, agents, officials, officers and sponsors form 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 ProHealth Physical Therapy 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 ProHealth Physical Therapy and Pilates Studio on or off its premises.

I also agree to indemnify and hold harmless ProHealth Physical Therapy 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 ProHealth Physical Therapy and Pilates Studio whether caused by the negligence of ProHealth Physical Therapy 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: ________________

Witness: __________________________________

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 (√) any of the following whose care you're under

___ Medical doctor (MD)
___ Osteopath
___ Dentist
___ Psychiatrist/Psychologist
___ Physical Therapist
___ Chiropractor
Other ________________
____

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/HOSPITALIZATION
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
________	____________________________	___________	__________________________
________	____________________________	___________	__________________________

1401 Georgian Park Suite 120
Peachtree City, GA 30269
770-487-1931

ProHealth Physical Therapy and Pilates Studio

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 **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? _________

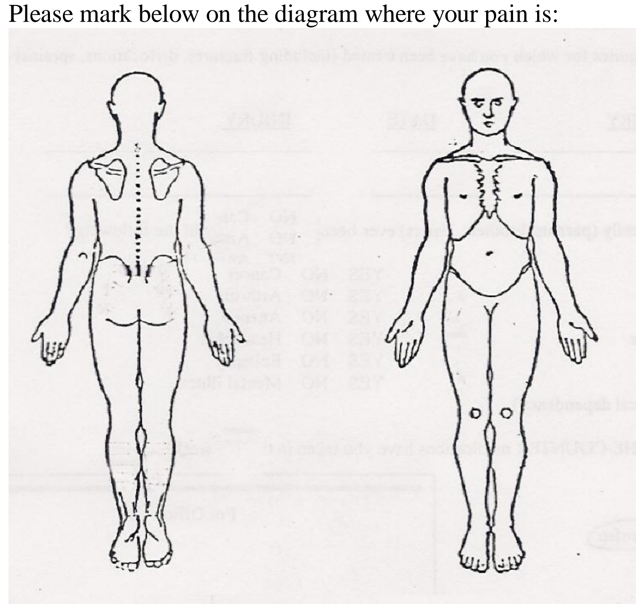
If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____________

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

Please mark below on the diagram where your pain is:



On a scale from 0 to 10 rate your pain:

Best:_________ Worst:_________ Current: ______

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

____

When did you first experience the pain?

Month/Year: _________________

What activities alleviate your pain?

____

What activities aggravate your pain?

____

Has your condition been getting better or worse?

____

1401 Georgian Park Suite 120
Peachtree City, GA 30269
770-487-1931

Are you currently participating in a regular exercise routine? YES NO If YES, What are you doing?

____

____

What are your goals/expectations from Physical therapy or Pilates?

____

How has your injury affected you emotionally?

□ Depression □ Withdrawal □ Anger □ Anxiety

□ Other: ______________________________ □ None

What is the severity of your emotional reaction (Scale of 1 (low) to 10 (high)): ____________

Who is your family/community support? ____

Is there any other information that would assist us with your care? ________________________________

PATIENT/GUARDIAN

Signature: __________________________

Date: ______________________________

THERAPIST

Signature: _______________________

Date: __________________________

1401 Georgian Park Suite 120
Peachtree City, GA 30269
770-487-1931