KINESPHERE PHYSICAL THERAPY & PILATES LLC

PLEASE FILL OUT THIS FORM TO THE BEST OF YOUR ABILITIES AND SIGN THE STATEMENT.

Name:	☐ M ☐ F	**DOB:**

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address:	**City:**	**State:**	**Zip:**
Home phone:	**Cell phone:**	**Work phone:**	
Email:	**Employer:**		
Emergency Contact:	**Phone numbers:**		
Recreational Activities:	**Frequency:**		

Previous Pilates Experience:

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Medications:

Goals for Fitness:

Previous Injuries: (Check all that apply)

☐Ankle ☐Knee ☐Hip ☐Low Back ☐Middle Back ☐Neck ☐Shoulder ☐Elbow ☐Wrists/hands

Elaborate on checked injuries:

All previous surgeries:

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)

☐ Arthritis	☐ Dizziness/vertigo	☐ Heart attack
☐ Back pain	☐ Falling history/balance issues	☐ High blood pressure
☐ Herniated disc	☐ Lack of coordination in walking	☐ Circulatory disease
☐ Spinal stenosis	☐ Neurologic disease	☐ Hearing problems
☐ Numbness/tingling in one or more extremity	☐ Diabetes	☐ Thyroid disorder
☐ Pelvic pain or sexual dysfunction	☐ Hypoglycemia	☐ Pregnancy (currently)
☐ Osteopenia (bone loss)	☐ Hyperglycemia	☐ Cancer
☐ Osteoporosis (bone loss)	☐ GERD/Acid reflux	☐ Joint replacement

Other/Please elaborate on boxes checked above:

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:_____

KINESPHERE PHYSICAL THERAPY & PILATES LLC

Release Agreement

I am aware that teachers of Kinesphere Physical Therapy LLC are dedicated to serving me by teaching me about and leading me in the practice of Pilates and other movement modalities. I understand that the practice of Pilates and other physical practices involve movement and exercise which may be strenuous and can carry some risk of injury and death. I understand that I must judge my own capabilities and limits regarding the practice of Pilates and other movement modalities used by Kinesphere Physical Therapy LLC. I agree to take full responsibility for not exceeding my limits and capabilities, as I engage in the practices taught by Kinesphere Physical Therapy LLC, and other teachers hired by Kinesphere Physical Therapy LLC. I agree to choose classes and activities at are within my capabilities. I also agree to take full responsibility for any injury I might suffer while in the practice of Pilates or any other movement discipline or modality taught or led by instructors.

I acknowledge that it is my responsibility to ascertain that there is no medical reason or physical limitation to prevent or inhibit my participation in Kinesphere Physical Therapy LLC instructional sessions. I also understand that it is my responsibility to inform Kinesphere Physical Therapy LLC instructors, at the beginning of any session about the presence of any injury or other condition that might affect my ability to participate. I agree to inform the instructor immediately if any injury occurs during the class.

I understand that Kinesphere Physical Therapy LLC instructors may physically adjust my posture and positioning as I engage in Pilates or other movement sessions. If I do not want such physical adjustments, I will inform the instructor at the beginning of each class I attend. I also acknowledge that if I want such adjustment, it is my responsibility to inform the instructor when an adjustment has gone far enough or when I desire no further adjustment.

I hereby waive and release any claim that I might have at any time for injury of any sort against Kinesphere Physical Therapy LLC or hired instructors involved therewith, including without limitations its principals, instructors, employees, agents and representatives.
I have carefully read this release, fully understand it and agree to abide by it.

Cancelation Policy

I recognize that Kinesphere Physical Therapy LLC has a minimum of 24 hours cancelation policy. If I fail to cancel my session in less than 24 hours, I will be responsible for paying a late cancel fee of $40. The exception to this policy is inclement weather. I will be required to pay my late cancel fee within 30 days of a missed session or before the next session can be scheduled, whichever comes first.

Refund Policy

I realize that there are no refunds for already provided sessions. Regarding packages purchased, there are no refunds, except when a medical letter can be provided.

I have read the above three policies and agree to abide by them.

Printed Name:

Signature:		Date:	
Witness:		Date:	