Member Registration Form

Personal Details:

Name: _____

Address: _____ City: _____PC _____

Phone/Cell: _____ Email: _____

Preferred Contact Method *(please circle):* phone email

Emergency Contact:

Name: _____ Relationship: _____

Best Contact Phone Number: _____

How did you hear about us?

Experience, Goals & Lifestyle:

Have you exercises in the past / present?	
What exercise related activities are you currently involved in	
Do you have any experience in Pilates?	❑ Matwork ❑ Reformer ❑ Barre (Ballet/Pilates/Dance) ❑ Yoga
Do you have any specific aims, objectives or expectations that you would like to meet?	❑ Flexibility/Stretching ❑ Muscle Toning ❑ Core Stability ❑ Posture ❑ Improved Fitness ❑ Improved Strength

	❑ Muscle Gain ❑ Balance/Coordination ❑ Stress Management ❑ Relaxation ❑ Weight Loss ❑ Resolve Muscle Imbalance
Are there any areas of your body you would like to focus on?	
Do you smoke cigarettes? If yes, how many per day?	
Do you drink alcohol? If yes, how many glasses per week?	
How much of your day do you spend sitting?	❑ Less than 1hr ❑ 1-2 hours ❑ 2-3 hours ❑ 3-4 hours ❑ 4-5 hours ❑ 6+ hours

Consent / Photo Consent:

Photos/Video's

At AWPilates and Wellness Centre we produce a wide range of materials to tell people about our services. From time to time we take photographic images (moving and still) of subjects, and use case studies which can include these images and personal data (such as name and/or information where appropriate and consented to) to enhance and illustrate our media applications to make them more accessible, and inspiring for our Clients

By completing this form, you give us full permission to use these images, which reasonably promote or advertise AWPilates & Wellness Centre (This may include our printed publications; adverts; audiovisual and electronic materials; website, Facebook, media work; display materials; and any other media we may use in the future.) The copyright of any material which is generated as a result of this photographic session shall be assigned and shall be the property of Rapid Fitness Thank you again for your help. If you *do not* wish to have your photo/video used please notify your instructor at the beginning of the class; and tick this box. ☐

Medical Information & Release

I understand that Pilates, like any other exercise, carried a risk of injury. Pilates is not physically demanding, however works with muscles that may be wear or inhibited, and therefore there is the chance of delayed onset muscle soreness. I understand that if I do not listen to my instructor or I continue with any exercise that causes me pain I am more likely to cause myself harm/injury. If any activity causes my pain to increase, I will notify my instructor immediately. By signing this form, I consent to Pilates and the risks associated.

Signed: _____ Date: _____

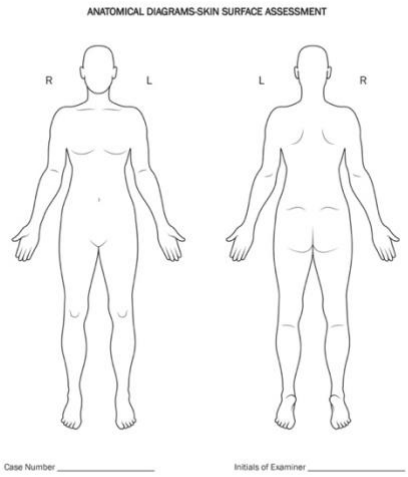
Health History:
Please outline below any health concerns we need to be aware of. If 'yes' to any of the following please provide a brief explanation.

Have you had, or do you have any of the following. If yes, please give details and current medication	❑ Heart Condition/Disease ❑ Heart Surgery ❑ Stroke ❑ Dizziness/fainting/blackouts ❑ Cancer ❑ Respiratory condition/ Disease ❑ Epilepsy ❑ Kidney Disease ❑ Asthma ❑ Diabetes ❑ Odema ❑ High Cholesterol ❑ High Blood Pressure ❑ Low Blood Pressure ❑ Thyroid Conditions ❑ Allergies
Do you have a direct relative who has had a stroke, heart attack or cardiovascular disease at less than 55 years of age?	
Do you ever have pains in your chest especially during physical activity?	
Have you experienced unreasonable breathlessness either at rest or with mild exertion?	
Have you ever been told by a Doctor or Physical Therapist that you should not exercise?	

Have you previously or are you currently experiencing any of the following conditions?	❑ Lower Back Pain ❑ Pelvic Pain ❑ Sciatica ❑ Spinal Conditions (e.g discs, scolioses) ❑ Musculoskeletal Injuries ❑ Arthritis/Bone or Joint Problems ❑ Osteoporosis ❑ Muscular Cramps
Have you had any recent injuries or surgery?	
Are there any movements that cause you pain?	
Do you have restricted movement in any joint?	
Pregnancy	YES NO If: Yes, How many weeks are you? _____ Have you had any complications? _____ ___ Have you had any of the following? __ Caesarean __ Diastasis Recti (abdominal separation)

Instructor NOTES:

_____



_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____