Classical Pilates Centre
Pilates and
Muscle Activation Techniques ®

Client Information

Name_____ Sex M F Date_____

Address_____ _____Postal Code_____

H. Phone _____ Mobile _____

Date of Birth_____ Age_____ E-Mail: _____

Your occupation_____

Have you ever done Muscle Activation Techniques™ (MAT) or Pilates? Y N

If yes, when?_____

Emergency Contact

In case of Emergency, contact _____Phone _____

Relation _____ Alt. Phone _____

Have you seen or are you currently seeing other health care practitioners for your current physical pain/complaint?

Name	Care Provided
_____	_____
_____	_____
_____	_____

Health & Fitness Information

To ensure that your exercise program is safe and designed to meet your needs, please respond to the following:

Do you exercise regularly? (3+ times/week) Yes No

Please rate your general level of fitness in the following areas:

Cardiovascular Conditioning:	Inactive	Low	Moderate	High
Muscular Strength	Weak	Moderate Strength		Very Strong
Flexibility:	Inflexible	Moderately Flexible		Very Flexible

Please rate your level of experience with the Pilates exercises.

	Matwork	Equipment	Both
No Experience	Beginner	Intermediate	Advanced

What do you hope to achieve by participating in this program? _____

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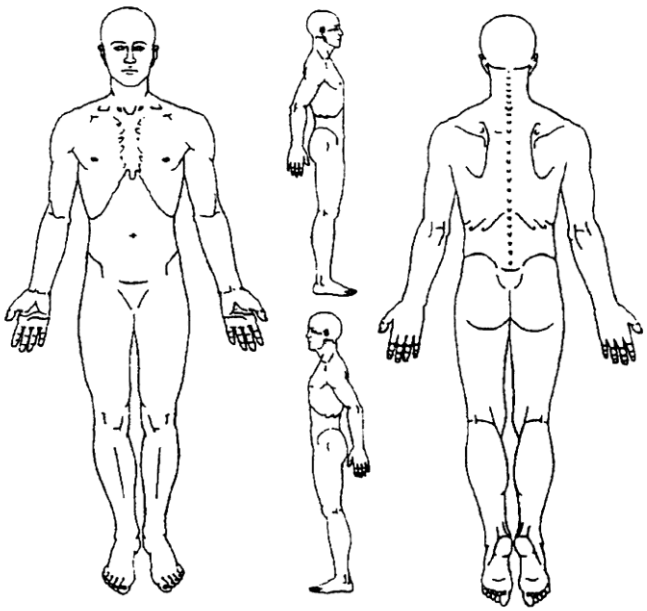
Primary reasons for visit:

_____

_____



Please describe pain, discomfort or injury. i.e. dull, aching, sharp, shooting, burning, deep, throbbing, etc. (use chart to indicate location):

_____

_____

_____

_____

_____

_____

_____

_____

Complaint began when and how? _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

_____

_____

Please list any current medications or supplements you are taking: _____

_____

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Health History

Please mark any of the following that you have now or have experienced:

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain Between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Menstrual Cramps
O Fever	O Asthma	O Weight Loss
O Loss of Balance	O Allergies	O Loss of Smell or Taste

Do you have rheumatoid arthritis or any other autoimmune disorder? Y N If Yes, please explain.

_____

_____

Describe any jaw pain you currently have or have ever had, such as TMJ pain. List any tooth extractions.

_____

Have you ever had any surgeries or broken bones? Y N If Yes, Please explain: _____

_____

Do you have any other medical conditions or previous illnesses or injuries that might be pertinent? _____

_____

_____

Please indicate the appropriate response.*

Have you ever been diagnosed with heart trouble?	Y	N	Ever taken medication for your heart?	Y	N
Does heart disease or stroke run in your family?	Y	N	Do you have high blood pressure?	Y	N
Do you or any immediate family have diabetes?	Y	N	Do you have arthritis, rheumatism or gout?	Y	N

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I understand that Kirk Smith is a practitioner of Muscle Activation Techniques™ and that Muscle Activation Techniques™ is **not** Chiropractic, Osteopathy, or Physiotherapy.

Signature _____ Date _____

Waiver of Liability
I subscribe to and accept the following: I acknowledge that Kirk Smith and Classical Pilates Centre will not render any medical services including medical diagnosis of my health condition(s). Neither Kirk Smith nor The Kirk Smith Studio shall be held liable for any damages arising from any personal injuries I might sustain in or around the premises in attending a session of Muscle Activation Techniques™ and or Pilates.
I further acknowledge that any activity, exercise program or bodywork technique might carry certain risks, and that I hereby fully and forever release and discharge Kirk Smith and the Kirk Smith Studio from any and all claims, demands, rights of action or cause of action, present and future, whether known or unknown resulting from sessions in Muscle Activation Techniques™.

Signature _____ Date _____

Cancellation Policy

There will be no charge for sessions that are cancelled with more than a 24 hours notice. Half price will be charged for all sessions cancelled with less than 24 hours notice.

PLEASE INITIAL THAT YOU HAVE READ THIS POLICY AND FULLY UNDERSTAND ITS MEANING:_____