Pilates Training Program - Waiver

The undersigned acknowledges he/she is aware of the inherent risks of participating in this, or any exercise program and its activities, and wishes to participate in, and assumes the risks associated with participation in the Pilates training program.

In consideration for participation in the Pilates training program, the undersigned does for themself, their family, heirs and assigns, voluntarily release, discharge, waive and relinquish any and all actions or causes of action including personal injury, property damage or wrongful death against Beaumont Health System, its directors, trustees, officers, employees, medical staff, agents or representatives for any causes of action arising out of or related in any manner to participation in the program.

The undersigned acknowledges and agrees that he/she read and understands the terms and conditions in this Waiver and accepts them as a member in the Pilates training program at Beaumont Health System, and signs this form voluntarily.

Member Name: (Print)

Member Signature

Date
William Beaumont Hospital
Pilates Health Questionnaire

Date ____________________________
Name___________________________________________________________
Profession________________________Email Address__________________

Please bring your own individual mat to use during your Pilates session and wear
comfortable clothes.

1. How did you hear about Beaumont’s Pilates
program?________________________________________________________
   Did someone refer you to us?____________________

2. Main reason for coming for Beaumont Pilates training? (please check all areas below
   that apply):
   _____Stronger Abdominals
   _____Slimmer/Leaner Muscles
   _____Improve Posture
   _____Reduce Pain
   _____Improve Strength
   _____Improve Flexibility
   _____Rehabilitate an Injury
   _____For Enjoyment
   _____Cross Train for Another Sport
   _____Other goals you may have_____________________________________

3. Have you had a recent medical evaluation?_____Were the results satisfactory?_____If
   not, please explain_______________________________________________

4. Have you had any traumatic injuries?_____If yes, what type and
   when?___________________________________________________________
   ________________________________________________________________

5. Do you have any injuries, aches or pains (recent or old)? _____If yes, please describe
   them_________________________________________________________________

6. Have you had any past surgeries, illnesses or accidents that have an impact on your
   ability to workout?_____If yes, please explain __________________________
7. What does your typical day involve physically? i.e., sitting, standing, walking, lifting, etc.________________________________________________

8. Please check below any medical conditions that apply to you:
   _____Acute joint pain or injury
   _____Asthma/Lung Disease
   _____Arthritis
   _____Osteoarthritis
   _____Degenerative Arthritis
   _____Rheumatoid Arthritis
   _____Blood Clot
   _____Bleeding Disorder
   _____Burning or shooting pain/discomfort
   _____Undiagnosed chronic pain/discomfort
   _____Cancer
   _____Diabetes
   _____Epilepsy
   _____Heart Disease
   _____High Blood Pressure
   _____Osteoporosis/Osteopenia
   _____Pregnant/Postpartum
   _____Shortness of breath
   _____Thyroid Problem
   _____Tightness in chest
   _____Seizures

(*You must provide written medical clearance from your physician, if you answered yes to having any of the above medical conditions. You must provide the medical clearance from your physician prior to beginning the first Pilates exercise session – and for each subsequent six week session you register for and in which you wish to participate.)

9. Are you menopausal or pre-menopausal? _____No_____Yes

10. Do you experience any tension, pain or difficulty in the areas of your:
    _____Neck
    _____Back
    _____Arms
    _____Legs
    _____Breathing
    _____Headaches
If you checked any of the above areas, please explain___________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
11. Please list any physical activities, exercise programs and/or sports in which you are currently participating ________________________________

12. Is there any other pertinent information that you could relate that would have an effect on your Pilates training? ________________________________

13. Are you presently doing other kinds of therapy? i.e., massage, physical and/or occupational therapy, chiropractic…_____no_____yes, if yes, please explain which types_______________________________________________

14. Have you had any previous Pilates training? _____no_____yes, if yes, where?__________________________________________________________

Print your name ____________________________________________________________________________

Your signature, or parent/guardian if you are less than 18 years old _______________________________________________________________________

Print name of emergency contact person, relationship _____________________________________________________________________________

Phone number of your emergency contact person ________________________________________________________________________________