

# WELCOME TO F.I.T.

The *Fusion Immersion and Transformation* Program

Please print and fill out as much as you can.

Don't worry about leaving blank spaces.

Client name: \_\_\_\_\_ Lead instructor: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

\_\_\_\_\_

I have completed the Fusion Pilates waiver separately (initial/date): \_\_\_\_\_

## Personal Evaluation and Goals

What are your main reasons for taking Pilates/Gyrotonic?

- Increase flexibility
- Improve posture/alignment
- Strengthen/balance back and core muscles
- Incorporate into already existing workout program
- Replace existing workout
- Manage stress
- Just want to try it
- Other: \_\_\_\_\_

In your own words, explain your motivation(s) for joining the F.I.T. program: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are the three main goals you hope to achieve with Pilates/Gyrotonic? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What other health or physical goals would you like to achieve over the next three months? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What long-term health or physical goals would you like to achieve over the next 12 months? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Will this be the first time that you have practiced Pilates/Gyrotonic? Y / N

If no, what classes have you attended in the past?

- |  |                              |                               |                                |                              |
|--|------------------------------|-------------------------------|--------------------------------|------------------------------|
| <input type="checkbox"/> Equipment:    | <input type="checkbox"/> 0-5 | <input type="checkbox"/> 5-10 | <input type="checkbox"/> 10-20 | <input type="checkbox"/> 20+ |
| <input type="checkbox"/> Mat:          | <input type="checkbox"/> 0-5 | <input type="checkbox"/> 5-10 | <input type="checkbox"/> 10-20 | <input type="checkbox"/> 20+ |
| <input type="checkbox"/> Private/Semi: | <input type="checkbox"/> 0-5 | <input type="checkbox"/> 5-10 | <input type="checkbox"/> 10-20 | <input type="checkbox"/> 20+ |

What is your current flexibility/stretching routine?

- Daily
- After exercise only
- Once a week
- Infrequently

What are your current sleeping habits?

- 8 hours
- 6 hours
- Less than 6 hours

Does your work or leisure activity involve any of the following for prolonged periods?

- Sitting
- Driving
- Bending
- Standing
- Lifting or moving heavy weights
- Other repetitive movements or postures

Please mark yes or no for the following questions:

Y / N Have you been told to only do physical activity recommended by a physician?

Y / N When you do physical activity, do you feel chest pain?

Y / N When not doing physical activity, have you had chest pain in the past month?

- Y / N Do you ever lose your balance because of dizziness, or lose consciousness?
- Y / N Is your blood pressure normal? If no, is it high or low? \_\_\_\_\_
- Y / N If your blood pressure is not normal, is it controlled with medication?
- Y / N Do you have insulin dependent diabetes?
- Y / N Have you ever been in a car accident resulting in trauma to the spine?
- Y / N Do you have any other spinal or neck problems?
- Y / N Do you have joint or bone problems that may be made worse by change in physical activity?
- Y / N Does osteoporosis run in your family?
- Y / N Do you have any lower back pain/problems or limited range of motion?
- Y / N Do you have pelvic or hip pain?
- Y / N Do you have any other reason you should not exercise or increase your physical activity?
- Y / N Have you had major surgery within the past ten years?
- Y / N Have you had minor surgery or sustained any injuries in the past two years?
- Y / N Do you have pain or restricted movement in any other joints (knee, ankle, elbow, shoulder)?
- Y / N Have you been diagnosed as hyper-mobile (excessive joint mobility)?
- Y / N Are there any movements that cause you pain? If so, please explain below.
- Y / N Are you taking any medications that may affect your ability to exercise?
- Y / N Are you currently being treated by a chiropractor?
- Y / N Are you currently being treated by a physical therapist?
- Y / N Are you currently being treated by an acupuncturist?
- Y / N Do you suffer from asthma? If yes, is it controlled with medication? Y / N
- Y / N Do you suffer from epilepsy? If yes, is it controlled with medication? Y / N
- Y / N Do you often get headaches?
- Y / N Are you 65 years of age or older?
- Y / N Are you pregnant? If yes, how many weeks in term are you? \_\_\_\_\_  
Due date: \_\_\_\_\_
- Y / N Have you been pregnant in the last six months? If yes, how was your baby delivered? \_\_\_\_\_

Please list any health problems not already mentioned that may affect your ability to exercise: \_\_\_\_\_  
\_\_\_\_\_

Please give full relevant details regarding *any* of the health issues listed on the previous page:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Please note that during this Pilates course, you will be expected to move from standing to lying. Would this be a problem for you? Y / N

Have you been referred to Pilates by a specialist practitioner? Y / N

If so, what kind?

- General practitioner
- Physiotherapist
- Chiropractor
- Osteopath
- Other: \_\_\_\_\_

Do you give permission for your instructor(s) to contact them? Y / N

Practitioner's name: \_\_\_\_\_

Practice name and address: \_\_\_\_\_

Practice phone:

\_\_\_\_\_

CONTINUED ON NEXT PAGE; PLEASE READ AND SIGN.

Please advise us before beginning any session if, for any reason, your health or your ability to exercise changes (i.e., muscle soreness, joint pain, pulled muscles, minor injuries, etc.). If you feel unwell (dizziness, sickness, etc.), it would be prudent not to attend class. This is primarily for your safety and well-being, and also in consideration for the comfort, well-being, and health of others in the studio.

Pilates exercises are very safe, but—as with all forms of physical exercise—it is wise to consult your doctor before starting Pilates sessions. It is not advisable to do Pilates between weeks 8 to 14 weeks of pregnancy, unless by special arrangement with your instructor. You should also wait six weeks after delivery before resuming exercise.

The sessions are not a substitute for medical counseling or treatment. If you have any doubts about the suitability of Pilates exercises, you should refer back to your medical practitioner. The instructors can accept no liability for personal injury related to participation in a session if your doctor has, on health grounds, advised against such exercise, or you fail to observe instructions on safety and technique.

You are responsible for your own body; listen to it and respect it. Your ability to perform exercises may vary from session to session depending on your state of well-being, fitness, tiredness, and/or stress level. Exercise should be performed at a pace that feels comfortable for you. Pain is the body's warning system and should not be ignored. Please inform your instructor immediately if you feel any discomfort during a session. Please also inform the instructor if you felt any discomfort after a previous session.

Initial: \_\_\_\_\_ I understand that Fusion Pilates exercises involve hands-on (tactile) correction, and I hereby consent for my teacher to work in this way.

Initial: \_\_\_\_\_ I confirm that I have read and understood the above advice, and that all of the information I have provided on this form is correct.

Client name: \_\_\_\_\_

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Instructor name: \_\_\_\_\_

Instructor signature: \_\_\_\_\_ Date: \_\_\_\_\_