PILATES PHYSIQUE

Client Information and Policy Form

Client Information

NAME: _____

ADDRESS: _____

CITY:_____ STATE:_____ ZIP:_____

HOME#:_____ CELL#:_____

EMAIL:_____

DATE of BIRTH:_____OCCUPATION:_____

How did you hear about us? _____

Who referred you? _____

Emergency Contact Info

NAME:_____

PHONE#:_____RELATIONSHIP:_____

Health History - Please circle all that apply:

Scoliosis	Fused disks	Herniated disks	Osteoporosis	Back surgery	Asthma
Sciatica	Arthritis	Plantar Fascitis	RA	Stress	Migraines
Glaucoma	Chronic Illness	Hi/low blood pressure	Low Flexibility	Knee/Hip/Shoulder	

Any surgery in last 12 months (*requires letter of consent from physician)*:_____

_____

Other Ailments: _____

_____

Are you pregnant or planning a pregnancy?_____ How many weeks (*requires letter of consent from physician)*? _____

Studio Booking and Payment Policies

- I understand that all appointments are subject to a 24-hour cancellation policy and that if I fail to cancel within 24 hours my account will be charged the full amount.
- There are no refunds or transfers of packages.
- All packages have an expiration date, there is a $15 charge to extend once expired.
- There is a $35 fee for all returned and/or bounced checks.

SIGNATURE:_____ DATE:_____

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