



# Pilates

## The Balanced Approach

Name:	_____		
Address:	_____	Postcode:	_____
Telephone:	day: _____	evening: _____	mobile: _____
e-mail:	_____		Date of birth: _____
Occupation:	_____		
Sports/Hobbies:	_____		
Previous Pilates Experience if any:	_____		
<b>Emergency Contact details:</b>	Name: _____	tel: _____	mobile: _____

**Work:** Does your work/sport/daily activity involve any of the following? (please tick)

- |                          |                          |                            |                          |
|--------------------------|--------------------------|----------------------------|--------------------------|
| Sitting for long periods | <input type="checkbox"/> | Driving                    | <input type="checkbox"/> |
| Bending                  | <input type="checkbox"/> | Standing for long periods  | <input type="checkbox"/> |
| Lifting heavy weights    | <input type="checkbox"/> | Repetitive actions         | <input type="checkbox"/> |
| Working at a computer    | <input type="checkbox"/> | Actions which cause strain | <input type="checkbox"/> |

### Health:

- |     |  | YES                      | NO                       |
|-----|--|--------------------------|--------------------------|
| 1.  | Do you have any sort of heart condition or defect?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.  | Do you feel pain in your chest when you do physical activity?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.  | Do you ever lose your balance because of dizziness or ever lose consciousness?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.  | Do you have arthritic joints osteoporosis or any bone or joint problems?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5.  | Do you suffer from back, neck or shoulder problems?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6.  | Do you have pain or restricted movement in any joints (e.g. hip, knee, ankle, elbow)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7.  | Have you been diagnosed as hypermobile (excessive joint mobility)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8.  | Have you had any injuries in the last year?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.  | Have you had surgery within the last five years?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | Are you taking any medication that could affect your ability to exercise?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. | Is your blood pressure: normal <input type="checkbox"/> high <input type="checkbox"/> low <input type="checkbox"/>   |                          |                          |
| 12. | Do you have: asthma/COPD <input type="checkbox"/> epilepsy <input type="checkbox"/> allergies <input type="checkbox"/>   |                          |                          |
| 13. | Are you pregnant or have you had a baby in the last year?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. | Is there any other reason why you should restrict physical exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. | Have you been referred by your GP or a specialist practitioner (e.g. GP, physio, chiropractor osteopath)? If so, and you give permission for me to contact them, please give their name and contact details below. | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered **YES** to any of the above it is advisable to consult with your doctor before starting Pilates classes. Please give below any further details, in confidence, to any questions answered **YES** or if there is any other relevant information that may affect your ability to exercise.

*Pilates classes are generally considered safe and effective. However, they are not intended to replace medical advice or treatment and if you have any doubt about the suitability of Pilates exercises for you, then seek advice from your medical or specialist practitioner. Exercise should be performed at a pace which feels comfortable for you. Please inform your instructor immediately if you experience pain or discomfort during a session or after a previous session. If your health changes so that subsequently you answer YES to any of the above, please inform your instructor. I understand that the information provided here, will be kept safely and securely in line with the Privacy Notice of Beryl Feely, a copy of which has been provided to me/details of which have been explained to me.*

**If you are unwell or have any of the symptoms of Covid19 please stay at home and keep yourself and others safe.**

**I agree to be contacted and sent information by Phone: YES/NO Text: YES/NO Email: YES/NO**

I confirm that I have read and understood the above and that the information I have given is correct.

Signed: \_\_\_\_\_ Name: \_\_\_\_\_

Date: \_\_\_\_\_



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### **PRIVACY NOTICE**

Personal data which you supply to me, including name, contact details, date of birth and relevant medical history, will only be used to communicate with you effectively regarding class or appointment information or to record details or monitor progress of your training session. I will not disclose this information to any other party unless required to do so by law.

All personal data, whether in paper form or digital, is held under secure conditions. This information will only be held for as long as required.

If you require further details of how your information is used, how the security of your information is maintained and your rights to access information held on you, please contact: [beryl@telfordbowenpilates.co.uk](mailto:beryl@telfordbowenpilates.co.uk) or [beryl.feely@gmail.com](mailto:beryl.feely@gmail.com) or tel: 01952 462896 or mobile: 07971 875372.

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