The Pilates Center of St. Louis

NEW CLIENT FORM

Full Name _____ **DOB** _____

Email _____

Phone _____

Address _____

City _____ **State** _____ **Zip Code** _____

How would you like us to confirm appointments? ☐ **Text** ☐ **Email**

Would you like to sign up for our email list? ☐ **Yes** ☐ **No**

Would you like to keep a credit card on file? ☐ **Yes** ☐ **No**

Studio Policies - Please Initial

_____ **Cancelation Policy -** We ask for 24 hours notice to cancel or reschedule appointments and group classes. Late cancelations and no-shows will result in a charge of the appointment value.

_____ **Joining Group Classes -** All of our group classes are intermediate level. An intro assessment and 5 Private Lessons is required for all new clients before joining group classes.

_____ **Refund Policy-** Refunds of unused account credits will be given up to 30 days after the purchase date. After 30 days credits can be transferred to another client. Purchases expire after 1 year.

Release of Liability

In signing below, I agree that Adamson Barfield Fitness LLC is in no way responsible for the safekeeping of my personal belongings while I attend class. I understand that classes at Adamson Barfield Fitness LLC may be physically strenuous, and I voluntarily participate in them with full knowledge that there is risk of personal injury, property loss, or death. I agree that neither I, my heirs, assign or legal representatives will sue or make any other claims of any kind whatsoever against Adamson Barfield Fitness LLC or its members for any personal injury, property damage/ loss, or wrongful death, whether caused by negligence or otherwise.

Signature _____ **Date** _____

Emergency Contact _____

Relationship _____ Phone _____

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Please mark any injuries, ailments, and significant medical treatments/surgeries. Indicate right (R) and left (L) if applicable.

- ☐ Arthritis
- ☐ Diabetes
- ☐ Osteoporosis/Osteopenia
- ☐ Stenosis
- ☐ Numbness/Tingling
- ☐ Migraines
- ☐ Heartburn/reflux/GERD
- ☐ Multiple Sclerosis
- ☐ Dizziness/Fainting
- ☐ Spondylolisthesis
- ☐ Neck Pain
- ☐ Asthma
- ☐ Scoliosis
- ☐ Back Pain
- ☐ Seizures/Epilepsy
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chronic Pain/Fibromyalgia
- ☐ Glaucoma
- ☐ Recent Surgery
- ☐ Herniated/ Fused Discs
- ☐ Sprain/Strain
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Shoulder Pain
- ☐ Others, please specify _____

Please elaborate on anything marked above: _____

_____

_____

Are you currently pregnant or may become pregnant? ☐ Yes ☐ No

Have you done Pilates before? ☐ Yes ☐ No **Please Explain:** _____

List all Previous and current activities/ sports

_____

List any specific fitness/health goals you are hoping to achieve through the Pilates method

_____

List best day/time availability

_____

How did you learn about us?

_____