New Client Registration

Name: _____ Date: _____

Address:_____

Phone: _____ Email: _____

Occupation: _____ Employer:_____

Date of Birth: _____ Age: ____ Height: _____ Weight: _____ Sex: M | F

Emergency Contact: _____ Phone: _____

Who referred you to Whole Pilates? | How did you hear about us?

_____

Overall Health: Excellent | Good | Fair | Poor | Other: _____

List Medications/Supplements: _____

_____

Recent Injuries/Surgeries: Foot-Ankle | Knee | Hip | Low or Mid Back | Shoulder | Elbow | Wrist-Hand | Neck

Please explain: _____

_____

Are you currently receiving any Health Care Services for a particular injury: Y | N

If yes, please circle: Medical | Chiropractic | Massage | Physical Therapy |

Other:_____

History of Exercise: None-Ever | None Recently | Occasional | Monthly | Weekly | Daily

Roughly how many hours a day do you: Sit ___ Stand ___ Walk ___ Lift ___

List activities you enjoy and participate in:

_____

Pilates Experience: None | Beginner | Intermediate | Advanced

Explain: _____

Pilates Goals & Objectives: Strength | Coordination | Posture | Balance | Overall Fitness
Please give further detail of goals and list anything you feel we should know for the safety of your participation: _____

_____

_____

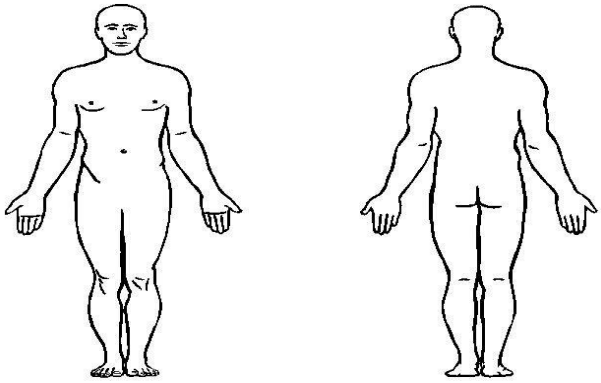
Please check if you are currently or have previously experienced any of the following:

___ Arthritis
___ Dizziness/Vertigo
___ Heart Attack
___ Back Pain
___ History of Falls/Loss of Balance
___ High/Low Blood Pressure
___ Herniated Disc
___ Lack of coordination with walking
___ Cancer
___ Spinal Stenosis
___ Diabetes
___ Acid Reflux/GERD
___ Numbness/tingling in arm/leg
___ Hyper/hypoglycemia
___ Thyroid Disorder
___ Pelvic Pain
___ Neurological disease
___ Joint Replacement
___ Osteopenia/Osteoporosis
___ Hearing Problems
___ Pregnancy

___ Recommended restriction of movement from a Healthcare Practitioner (e.g., lifting | bending | arching | shoulder rotation)
Please explain any checked areas: _____

_____

Use the body chart to circle any areas of pain or discomfort:



Please rate pain on a scale of 1-10:

1 = Barely Noticeable	5 = Uncomfortable & Disturbing	10 = Debilitating & Unmanageable

_____

_____

What makes your pain worse or better? _____

_____

I have completed the new client information, truthfully and accurately to the best of my knowledge.

Signature: _____ **Date:** _____

Payment & Cancellation Policy

I understand that I am financially responsible for payment of my Pilates session with a credit card on file. I understand that my credit card information will be in an encrypted format that will not be utilized for any other purposes.

I agree to give 24 hour notice for cancellation of a scheduled appointment and understand that my account will be charged for any missed session, without proper notice.

All sessions are either 55 or 30 minutes. Regardless of arrival time, sessions will end at the scheduled time.

I have read and voluntarily agree to the terms and conditions stated above.

Signature: _____ **Date:** _____

WHOLE PILATES STUDIO: Terms of Service and Release of Liability

These Terms of Service form a legal agreement between Spirit of Health KC, LLC, d/b/a Whole Pilates Studio ("**Whole Pilates**"), and the individual completing a registration for Pilates services whether in-person or at www.wholepilatesstudio.com (hereafter, **"I", "me", "my"**), and regardless of whether the Pilates services are delivered in-person or via any downloadable software program that I am accessing or installing on my device or personal computer and the services available through that software program.

1. I understand that the process of doing Pilates may involve dialog, questions regarding my history, previous injuries, current status, etc., and that my clear and complete responses to these questions will determine the quality and safety of the exercises.

2. I understand that Pilates involves unique equipment that I may not be familiar with; that the equipment is constructed of moving parts, springs, and levers; and that the movement of my body and the apparatus could result in the possibility of falling or being trapped by the moving parts. I understand that my clear and focused involvement is necessary for my physical improvement and safety.

3. I understand that my participation may require the instructor to move me or ask me to move my body in ways that are new to me, and it is possible that in these movements pain or injury may occur or be exacerbated. I understand that it is my responsibility to communicate clearly and promptly with my instructor, telling the instructor of any pain, discomfort, medical findings, or physical limitations. I understand that it is my responsibility to stop any movement or exercise that I feel is too much for me or may cause me pain or injury.

4. I understand that it is my sole responsibility to consult with a physician prior to my participation in Pilates to determine my fitness level and safety of participation. I represent and warrant that if I have recently experienced a new injury or illness, if I am or may be pregnant, if I am post-partum, or if I have concerns of osteoporosis, multiple sclerosis or other significant neurological or physical dysfunction, I have consulted with my physician and obtained my physician's approval for participating in Pilates.

5. I recognize and understand that there are risks of physical injury inherent in participation in any physical exercise program and that those risks are increased with the use of exercise equipment, particularly the unique equipment used in Pilates instruction. I also understand that exercise equipment, particularly the moving parts, may be subject to fatigue or other wear and tear that may not be readily apparent to the user or to the Pilates studio. I KNOWINGLY ASSUME THE RISKS INVOLVED IN TAKING PILATES INSTRUCTION (WHETHER IN-PERSON OR ONLINE) AND USING PILATES EQUIPMENT.

6. I represent and warrant that I am at least 18 years of age. Alternatively, I agree that if I am under 18 years of age, I will disclose my age to Whole Pilates and have my parent or legal guardian sign a release form.

7. I understand that any audio or video recording of Pilates sessions is strictly prohibited unless expressly agreed to in writing by Whole Pilates. I promise and agree that I am using the Pilates services for my own personal, noncommercial purposes and will not redistribute and transfer the services to anyone else. I agree that I will not provide my password or other account information to anyone else or knowingly allow someone else to use my password or other account information to access the services.

8. IN FURTHER CONSIDERATION FOR MY PARTICIPATION IN THE PILATES SERVICES, I KNOWINGLY, VOLUNTARILY AND EXPRESSIVELY WAIVE AND RELEASE ANY CURRENT OR FUTURE CLAIM I MAY HAVE AGAINST WHOLE PILATES, ITS EMPLOYEES, SHAREHOLDERS, CONTRACTORS, INSTRUCTORS, DIRECTORS, OFFICERS, AGENTS, SUCCESSORS AND ASSIGNS (THE “RELEASEES”) ARISING OUT OF OR ATTRIBUTABLE TO MY PARTICIPATION IN THE PILATES CLASSES, WHETHER ARISING OUT OF THE NEGLIGENCE OF WHOLE PILATES, OR ANY RELEASEES OR OTHERWISE. I COVENANT NOT TO MAKE OR BRING ANY SUCH CLAIM AGAINST WHOLE PILATES, OR ANY OTHER RELEASEE, AND FOREVER RELEASE AND DISCHARGE WHOLE PILATES, AND ALL OTHER RELEASEES FROM LIABILITY UNDER SUCH CLAIMS.

9. These Terms of Service and any dispute or controversy arising out of or related thereto (“Claims”) shall be governed by and construed, interpreted and resolved in accordance with the laws of the State of Missouri without regard to its choice of law provisions; provided, however, that any procedural or substantive Claim conflicting with or falling under the exclusive jurisdiction of United States federal law shall be governed by, and construed, interpreted and resolved in accordance with United States federal law without regard to its choice of law provisions. All Claims shall be submitted exclusively to the federal and state courts of competent jurisdiction located in Kansas City, Missouri, and the parties hereby unconditionally and irrevocably consent and submit to such exclusive jurisdiction and venue and waive any objection they may now or hereafter have with respect thereto.

I have read the above Terms of Service and fully understand its contents. I voluntarily agree to the terms and conditions stated above.

SPIRIT OF HEALTH THERAPIES: Release and Waiver of Liability

The individual named below (**“I” or “me”**) desires to participate in one or more therapy sessions provided by Spirit of Health KC, LLC, d/b/a Spirit of Health (**"Spirit of Health"**), a Missouri limited liability company, which may include, but is not limited to, one or more of the following forms of therapy: Far Infrared Sauna, iMRS, Lymph Vibra Therapy, True Rife, Ionic Detox Foot Bath, or any other forms of therapy provided by Spirit of Health. As lawful consideration for being permitted by Spirit of Health to participate in the Sessions and the intangible value that I will gain by participating in the Sessions, I agree to all the terms and conditions set forth in this agreement (this “**Agreement**").

Services Disclaimer. I understand and realize that Vaughn Lawrence and Mike Casey are lay natural health advisors, and NOT medical doctors or licensed physicians. I understand that the Sessions are in no way medical treatments nor are they intended to diagnose, treat, prescribe, advise or cure any condition. I understand that the Sessions do not guarantee any particular health-related results. I understand that the Sessions cannot determine specific disease conditions I may or may not have and do not replace the diagnostic services offered by a licensed physician.

Assumption of Risk. I am aware of and understand the risks inherent in the use of the particular therapy utilized during the Sessions. I VOLUNTARILY ASSUME THE RISK OF INJURY, ACCIDENT, OR DEATH WHICH MAY ARISE FROM THE USE OF THE PARTICULAR THERAPY UTILIZED DURING THE SESSIONS. I acknowledge that I am voluntarily participating in the Sessions with knowledge of the potential danger involved and hereby agree to accept and assume any and all risks of injury, accident or death, whether caused by the negligence of Spirit of Health or otherwise. I further acknowledge that I have received and read through the instructions and warnings related to the particular therapy utilized during the Sessions.

Liability Release. IN FURTHER CONSIDERATION FOR MY PARTICIPATION IN THE SESSIONS I KNOWINGLY, VOLUNTARILY AND EXPRESSLY WAIVE AND RELEASE ANY CURRENT OR FUTURE CLAIM I MAY HAVE AGAINST SPIRIT OF HEALTH, ITS EMPLOYEES, SHAREHOLDERS, CONTRACTORS, INSTRUCTORS, DIRECTORS, OFFICERS, AGENTS, SUCCESSORS AND ASSIGNS (THE "**RELEASEES**") ARISING OUT OF OR ATTRIBUTABLE TO MY PARTICIPATION IN THE SESSIONS, WHETHER ARISING OUT OF THE NEGLIGENCE OF SPIRIT OF HEALTH OR ANY RELEASEES OR OTHERWISE. I COVENANT NOT TO MAKE OR BRING ANY SUCH CLAIM AGAINST SPIRIT OF HEALTH OR ANY OTHER RELEASEE, AND FOREVER RELEASE AND DISCHARGE SPIRIT OF HEALTH AND ALL OTHER RELEASEES FROM LIABILITY UNDER SUCH CLAIMS. I also understand that any foods or supplements I choose to consume, or any natural therapies I choose to pursue are at my own discretion, of my own free will and at my own risk. I also understand that all third-party information in the form of fliers, pamphlets and articles received by me are for informational and educational purposes only, and do not necessarily reflect the viewpoints of Spirit of Health. I further acknowledge and agree all waivers, releases and covenants made herein are binding on me, my family, estate, heirs or legal representatives.

I further acknowledge that it is my responsibility to contact and consult with my primary care physician before starting or engaging in any natural health program, diets, supplements, or therapies. I will not discontinue, change or alter any medications or therapies that have been prescribed for me by a physician without first consulting the prescribing physician. I certify that I am participating in the Sessions and all further communication with Spirit of Health, whether in person, or by mail, telephone, email, text message, video conference or any other form electronic communication, solely on my own behalf and not as an agent or representative of any federal, state, county, or local government or private agency on a mission of investigation.

This Agreement constitutes the sole and entire agreement of Spirit of Health and me with respect to the subject matter contained herein and supersedes all prior and contemporaneous understandings, agreements, representations, and warranties, both written and oral, with respect to such subject matter. If any term or provision of this Agreement is invalid, illegal, or unenforceable in any jurisdiction, such invalidity, illegality, or unenforceability shall not affect any other term or provision of this Agreement or invalidate or render unenforceable such term or provision in any other jurisdiction. This Agreement is binding on and shall inure to the benefit of Spirit of Health and me and their respective successors and assigns. All matters arising out of or relating to this Agreement shall be governed by and construed in accordance with the internal laws of the State of Missouri without giving effect to any choice or conflict of law provision or rule. Any claim or cause of action arising under this Agreement may be brought only in the federal and state courts located in Jackson County, Missouri, and I hereby consent to the exclusive jurisdiction of such courts.

Consent. I have carefully read, fully understand and agree to the terms of this Agreement.

Print Name: _____

Signature: _____ Date: _____

(Parent/guardian sign if under 18)