Therapeutic Pilates- Intake Form

Patricia Oys PT, DPT, MSPT, CEEAA, PMA ®-CPT
Doctor of Physical Therapy
National Certified Pilates Method Alliance
Pilates Instructor-PhysicalMind
Polestar Pilates Practitioner
APTA Certified Expert in Exercise for the Aging Adult

952-649-8792
Email: therapeuticpilatespt@gmail.com

Please fill out each page, sign consent form and either return back to me via email or bring to your first Pilates session. If any questions, please call.

Therapeutic Pilates-Intake Form

Patricia Oys PT, DPT, MSPT, CEEAA, PMA ®-CPT
952-649-8792 or email therapeuticpilatespt@gmail.com

Date: _____

Health and Background Information

Personal Background

Name: _____ **Home Phone:** _____
Address: _____ **Cell Phone:** _____
_____
City: _____ **Work Phone:** _____
State: _____ **Zip:** _____
Referred By: _____

Physician (Please include first name):

Name: _____ **Phone #**_____
Specialist (if applicable) _____ **Phone #**_____
Address: _____ **Date of last exam:** _____

Emergency Information:

Persons to be notified in case of emergency:

Name:_____ **Relationship:**_____
Home Phone#: _____ **Work Phone #:** _____ **Other:** _____

Name: _____ **Relationship:** _____
Home Phone#: _____ **Work Phone#:** _____ **Other:** _____

Health Goals

- ○ **Increase Strength**
- ○ **Flexibility**
- ○ **Posture**
- ○ **Weight loss**
- ○ **Add variety to current exercise program**
- ○ **Rehabilitation (Specify)**

Notes: _____
_____
_____
_____

_____

- ○ **Other:** _____

_____

Work History:

Occupation: _____ **Job Responsibilities:** _____

_____

What are the postural requirements of your job? _____

_____

Exercise Information:

Have you tried Pilates before? Yes No
If yes, what did you like or dislike about it? _____

_____

How often do you exercise per week? (circle one)

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

Describe what type of exercise that you do on a regular basis: _____

_____

Which commitments (if any) are most likely to interfere with your program, or have interfered with a program in the past: _____

_____

Have you seen a physical therapist in the past one year? ____ yes _____ no
If yes, please describe why you had PT intervention._____

_____

Name of physical therapist: _____ **Phone number:**_____

Therapeutic Pilates
Patricia Oys PT, DPT, MSPT, CEEAA, PMA ®-CPT
952-649-8792 or email therapeuticpilatespt@gmail.com

Cancellation Policy

I appreciate a twenty-four (24) hour notice of cancellation in order to accommodate all of my clients' needs. Thank you for your courtesy to my schedule and other clients. Late cancels and failed appointments will be billed 100% of fee.

*** If Therapeutic Pilates cancels your session in less than 24 hour notice, you will be given one session at no charge.

Arriving Late

Please make every effort to be on time for your appointment. If you arrive late we will need to follow your regularly scheduled appointment and you will be billed for the full session.

_____ _____

Signature **Date**

Therapeutic Pilates
Patricia Oys PT, DPT, MSPT, CEEAA, PMA ®-CPT
952-649-8792 or email therapeuticpilatespt@gmail.com

Liability Release and Informed Consent for Exercise Participation

I desire to participate voluntarily in the exercise program with Patricia Oys PT, DPT, MSPT and **will obtain written permission from my physician prior to the commencement of any exercise program.**

I understand that the purpose of the exercise program is to develop and maintain cardiovascular conditioning, strength training, body composition, flexibility and endurance. A specific exercise plan will be designed for me, based on my health history, current capacity, lifestyle and desired goals. The program will gradually place an increasing workload on the body to improve overall fitness. The rate of progression is individual and is regulated by perceived effort and quality of performance of the exercise. Some individuals may experience abnormalities of blood pressure, heart rate or other contraindications.

In consideration for being allowed to participate in the exercise program with Patricia Oys PT, DPT, MSPT **I agree to assume the risk of such exercise, and further agree to hold harmless Therapeutics Pilates/ Patricia Oys from any and all claims, suits, losses, or related causes of action** for damages, including, but not limited to, such claims that may result from my injury or death- accidental or otherwise- during or arising in any way from the exercise program.

I affirm that I have stated all of my known medical conditions, answered all questions honestly and agree to keep Patricia Oys updated as to any changes in my medical and physical condition.

In signing this consent form, I affirm that I have read this form in its entirety and that I understand the nature of the exercise program. I also affirm that my questions regarding the exercise program have been answered to my satisfaction.

_____ _____

Signature Date

Health Profile

Name: _____
Address: _____
_____
Telephone: H: _____
Cell: _____

Have you ever been told you have:

Cancer	Yes	No
Diabetes	Yes	No
High blood pressure	Yes	No
Heart Disease	Yes	No
Angina/chest pain	Yes	No
Stroke	Yes	No
Osteoporosis/Osteopenia	Yes	No
Osteoarthritis	Yes	No
Rheumatoid Arthritis	Yes	No

Do you have a history of

Allergies/Asthma	Yes	No
Headaches	Yes	No
Bronchitis	Yes	No
Kidney Disease	Yes	No
Rheumatic Fever	Yes	No
Ulcers	Yes	No
Seizures	Yes	No

In the past 3 months have you had or do you experience:

A change in you health	Yes	No
Nausea/Vomiting	Yes	No
Fevers/chills/sweats	Yes	No
Unexplained weight change	Yes	No
Numbness or tingling	Yes	No
Changes in appetite	Yes	No
Difficulty swallowing	Yes	No
Changes in bowel function	Yes	No
Changes in bladder function	Yes	No
Shortness in breath	Yes	No
Dizziness	Yes	No
Upper respiratory infection	Yes	No
Urinary tract infection	Yes	No
Change in balance (increase in falls)	Yes	No

Are you currently:

Pregnant	Yes	No
Depressed	Yes	No
Under Stress	Yes	No

Do you or have you in the past smoked tobacco? Yes No
If yes, _____ packs per day
Last tobacco use _____

Do you drink alcoholic beverages?
Yes No
If yes, how many drinks do you routinely have per week? _____/week.

Any falls in the last 1 year Yes No

Date of last physical examination _____

Client Signature: _____

Therapist/Trainer Signature: _____