

Margaret Caruvana

Pilates Based Personal Training Services

Training Policies

- Trainer(s) are to be notified 24 hours prior to session in the case of a cancellation. You may reschedule for the same day if you wish to utilize session, otherwise session is forfeited and charge incurred. Notice of a cancellation should be in the form of a text first, or phone call if you do not get a response within 15 minutes of sending text to confirm the trainer got the message.
- All sessions start and end at time agreed too.
- It is the participant's responsibility to notify their Trainer of any change in health status.
- Be sure to have a light snack or meal, and plenty of water, before training sessions to prevent fatigue during the workout.

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Waiver, Release and Hold Harmless Agreement

I, _____, the undersigned, affirm that I am
(Print name)

Participating voluntarily in Pilates Personal Training Services.

I (together with my parent or guardian, if I am under the age of eighteen or under a legal disability) represent covenant and agree, on behalf of myself and my heirs, assigns, and any other person claiming by, under, or through me, as follows:

I acknowledge that participating in the above noted activity involves certain risks (some of which I may not fully appreciate) and that injuries, death, property damage, or other harm could occur to me or others. I accept and voluntarily incur all risks of any injuries, damages, or harm which arise during or result from my participation in the above activity. I understand and am aware that physical activity, including the use of equipment, is potentially hazardous activity, and I hereby agree to expressly assume and accept any and all risk. It is strongly recommended that each participant have an annual physical examination and carry personal health and accident insurance.

I waive all claims against Margaret Caruvana, agents or insurers (Released Parties) for any injuries, damages, losses or claims, whether known or unknown, which arise during or result from my participation in the above activity. I release and forever discharge the Released Parties from all such claims.

I agree to indemnify and hold the Released Parties harmless from all losses, liabilities, damages, costs or expenses (including but not limited to reasonable attorneys' fees and other litigation costs and expenses) incurred by any of the Released Parties as a result of any claims or suits that I (or anyone claiming by, under or through me) may bring against any of the Released Parties to recover any losses, liabilities, costs, damages, or expenses which arise during or result from my participation in the above activity.

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I have carefully read and reviewed the Waiver, Release and Hold Harmless Agreement. I understand it fully and I execute it voluntarily.

EXECUTED this _____ day of _____.

Signature (if 18 or over)

Parent or Guardian Signature (if under age 18) Parent or Guardian Printed Name
(if under age 18)

Client Data Questionnaire

This information will help us to track your progress. Please answer each of these questions as accurately as you can. All responses are confidential.

Today's Date:

Your Name:

Gender:

Date of Birth:

Address:

City:

State / Zip:

Cell Phone:

Email Address:

Emergency Contact:

Physician's Name:

Male Female

Phone: _____

Email: _____

Medical Screening - PAR Q

Please follow the directions for completing the Physical Activity Readiness Questionnaire (PAR-Q). **If you check YES for any conditions, you will be asked to obtain medical clearance prior to beginning your personal training sessions.**

If you are planning to become much more physically active than you are now, start by answering the seven questions below. If you are between the ages of 15-69, the Par-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor. Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly.

- | | YES | NO | |
|----|--------------------------|--------------------------|--|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Do you feel pain in your chest when you do physical activity? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | In the past month, have you had chest pain when you were not doing physical activity? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Do you lose your balance because of dizziness or do you ever lose consciousness? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have a bone or joint problem that could be made worse by a change in your physical activity? |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Do you know of any other reason why you should not do physical activity? |

Please note: if your health changes so that you answer YES to any of the above questions, you are required to inform your personal trainer and speak with your physician to obtain a physician's clearance document.

If you answered YES to one or more questions:

Talk with your doctor BEFORE you start becoming much more physically active or BEFORE you have a fitness assessment.

If you answered NO to all questions:

You can be reasonably sure that you can start becoming more physically active. Begin slowly and build up gradually. This is the safest and easiest way to go.

I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction.

Name _____

Signature _____ Date _____

Signature of Parent _____

(for participants under the age of 18)

Medical Screening - Health History

Are you taking any medications, supplements or drugs? If yes, please explain and identify:

Do you now, or have you had in the past: (if yes, please explain)	YES	NO
1. History of heart problems, chest pain or stroke	<input type="checkbox"/>	<input type="checkbox"/>
2. Increased blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
3. Any chronic illness or condition	<input type="checkbox"/>	<input type="checkbox"/>
4. Difficulty with physical exercise (knee, back, foot issues...)	<input type="checkbox"/>	<input type="checkbox"/>
5. Recent surgery (last 12 months)	<input type="checkbox"/>	<input type="checkbox"/>
6. Pregnancy (now or within last 3 months)	<input type="checkbox"/>	<input type="checkbox"/>
7. History of breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>
8. Muscle, joint, or back disorder, or any previous injury still affecting you	<input type="checkbox"/>	<input type="checkbox"/>
9. Diabetes or thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>
10. Cigarette smoking (packs per day, how many years, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
11. Increased blood cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
12. Hernia, or any condition that may be aggravated by lifting	<input type="checkbox"/>	<input type="checkbox"/>
13. Fainting, lightheadedness, blackouts, seizure, or epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
14. Severe or recurrent headaches	<input type="checkbox"/>	<input type="checkbox"/>
15. Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>

Signature: _____ **Date:** _____

Personal Fitness Goals Questionnaire

Please indicate your personal health and fitness goals by checking the following boxes:

- Lose weight Improve nutrition Increased confidence
 - Gain weight Sports specific Flexibility
 - Reduce stress Lower cholesterol Muscular endurance/toning
 - Muscular strength/size Aerobic fitness General fitness
 - Change body composition (body fat %)
-

Please tell us more about your exercise patterns and goals:

What have been your past barriers to meeting your health and fitness goals?

What is your current motivation level to meet your goals?

How confident are you in your ability to reach your goals?

How would you measure success in your exercise program?

How much time are you willing to devote to an exercise program?

____ minutes/day ____ days/week

How much time do you currently devote to an exercise program?

____ minutes/day ____ days/week

Are you currently involved in regular cardiovascular exercise?

Yes No If yes, please indicate type(s) (i.e. running) _____

Are you currently involved in regular strength training?

Yes No If yes, please specify _____

Please rate your exercise level on a scale of 1 to 5 (5 indicating very strenuous) for each age range through your present age:

15-20 _____ 21-30 _____ 31-40 _____ 41-50 _____ 51+ _____

Do you have any negative feelings toward, or have you had any bad experiences with, physical activity?

Yes No If yes, please specify _____

Do you have any negative feelings toward, or have you had any negative experience with fitness testing and evaluation?

Yes No If yes, please specify _____