Pilates and Physiotherapy Pre-Screening Questionnaire and Agreement

Name: _____ **Date of Birth:** ___/___/_____ **Gender: F / M**

Street Number & Name: _____

Suburb: _____ **Postcode:** _____

Email: _____ **Appoint. Reminders (circle one) Text / Email**

Mobile Number: _____ **Home Number:** _____

Emergency Contact: _____ **Phone Number:** _____

Occupation: _____ **Private Health Insurer:** _____

Referring Medical Practitioner: _____

How did you hear about us?: _____

Has your doctor ever told you that you have a heart condition or have ever suffered from a stroke?	Yes ☐ No ☐
Do you ever feel unexplained pains in your chest at rest or during physical activity/exercise?	Yes ☐ No ☐
Do you feel faint or have spells of dizziness during physical activity/exercise that causes you to lose balance?	Yes ☐ No ☐
Have you had an asthma attack requiring immediate medical attention anytime over the last 12 months?	Yes ☐ No ☐
If you have diabetes (Type I or Type II) have you had trouble controlling your blood glucose in the last 3 months?	Yes ☐ No ☐
Do you have any other medical condition(s) that may prevent you from participating in physical activity/exercise?	Yes ☐ No ☐
Are you pregnant or have you given birth in the last 6 weeks?	Yes ☐ No ☐

Birth History (Females only)

Have you had children? If yes, please give dates and details (i.e. natural or caesarean, complications):

_____

_____

Have you had, or do you have, any pain or major injuries in the following areas (please ☑ and provide details)?

☐ Neck Details: _____

☐ Shoulder Details: _____

☐ Back Details: _____

☐ Hips Details: _____

☐ Knee Details: _____

☐ Ankles Details: _____

☐ Other Details: _____

Do you have, or have you ever had (please indicate with a ☑):

Osteoporosis	Yes ☐	No ☐
Gout	Yes ☐	No ☐
Asthma	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐
Hernia	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐
Rheumatic Conditions	Yes ☐	No ☐
Cancer: Please give details _____	Yes ☐	No ☐
Any heart condition: Please give details _____	Yes ☐	No ☐
High blood pressure	Yes ☐	No ☐
Reflux	Yes ☐	No ☐
Do you have any hot, red or swollen joints?	Yes ☐	No ☐
Infectious Diseases: Please give details _____	Yes ☐	No ☐

Can you think of any other reason to modify your exercise program?

_____

<u>Current Exercise Regime:</u>

Current exercise type: _____

Frequency: _____

Intensity: Light ☐ Moderate ☐ Vigorous ☐

Have you done Pilates previously? Please give details: _____

_____

What are your Pilates goals? _____

_____

Terms, Conditions and Waiver

I, _____ (print name), agree that the information I have given on this form is true and correct. I have read and understood all wording printed on this document and take full responsibility for my actions at any and all times on the premises and common areas of Pilates Power and Physiotherapy Cronulla Pty Ltd and during any classes or studio sessions, and in the use of equipment in any way whilst engaging in activities on the above premises. Should any health conditions apply, I shall obtain medical clearance from my general practitioner or allied health practitioner as appropriate prior to commencing. I understand that it is my responsibility to inform Pilates Power and Physiotherapy Cronulla Pty Ltd of any illness, injury, medical or physical condition that may occur at any time and that may affect my health or wellbeing whilst undertaking Pilates exercise or other services with Pilates Power and Physiotherapy Cronulla Pty Ltd.

I agree to abide by the following terms and conditions for any services booked and/or purchased from Pilates Power and Physiotherapy Cronulla:

- Services purchased/booked are non-transferrable and non-refundable.
- If I need to change or cancel my studio appointment I must let Pilates Power and Physiotherapy know at least 24 hours prior to the appointment time, otherwise the relevant service fee will be charged to my account and/or a visit deducted from my pre-purchased pack of sessions.
- All packaged studio sessions (10 pack, 20 pack and 30 pack) must be used within four (4) months of date of purchase unless alternative arrangements have been agreed upon with Pilates Power and Physiotherapy Cronulla.
- Clean socks must be worn when participating in studio/matwork sessions. My own clean towel is required for use in matwork classes.
- Pilates Power and Physiotherapy Cronulla reserves the right to substitute instructors when necessary.

Signed: _____ Date: ___ / ___/ _____

Please turn over

Physiotherapy, Treatment and Pilates Information and Disclaimer

Physiotherapy Treatment is generally an effective and safe form of treatment, however, like any treatment there are benefits and risks. The purpose of this form is to let you know what your rights are and how we can address the issue of collaborative decision making and informed consent between the physiotherapist and the patient.

Physiotherapists in this practice will discuss your condition and options for treatment with you so that you are appropriately informed and can make decisions relating to treatment. You may choose to consent or refuse any form of treatment for any reason including religious or personal grounds. Once you have given consent, you may withdraw that consent at any time.

Please read the following, and sign below:

Questions of a personal nature
Your physiotherapist or Pilates instructor may ask personal questions relating to your physical condition or injury and how your injury impacts on your activities of daily living. The more information you provide, the more likely it is that the physiotherapist or instructor can provide effective treatment or Pilates instruction. It is your choice as to what information you choose to provide. If you feel uncomfortable with a particular question, or groups of questions, please let the physiotherapist or Pilates instructor know and they will cease.

Physical Contact
During the examination, assessment, treatment, and/or instruction it may be necessary for your physiotherapist or Pilates instructor to make physical contact. Your physiotherapist or instructor will ask your permission before making physical contact in any way. Wherever possible, contact will be made using a towel or other form of screening. Physical contact requires your express consent. You may withdraw that consent at any time, at which point all physical contact will cease immediately. Please inform your physiotherapist or instructor if you feel uncomfortable at any time.

Risks Related to Physiotherapy Treatment
As with all forms of treatment, there are risks and benefits. The physiotherapist will discuss any foreseeable risks with you prior to administering treatment. In some cases, the physiotherapist may ask you to read information related to a particular treatment and they may request that you sign a further consent form. This is to ensure that you fully understand any risks involved. You may withdraw consent at any time even if you have previously signed a consent form.

Children and Minors
Consent from a custodial parent is required to treat a minor.

Substituted Consent
Where a person is incapable of understanding the risks and benefits of treatment, consent may be provided by another person legally authorised to provide such consent. Evidence of legal authorisation is required in such circumstances.

You need to let us know
The risks related to some treatments can increase if the physiotherapist is unaware of certain facts. Please inform the physiotherapist if you have:

- A pacemaker or heart condition
- Suffered from blood clots, thrombosis or stroke
- Suffer from diabetes
- Are currently taking medication

I, _____ (full name), have read and understood the above statements relating to consent for treatment and/or Pilates instruction. I offer my consent to receive treatment and/or Pilates instruction with this practice. I agree to this consent remaining valid until such time as I withdraw my consent.

Signed: _____ Date: _____/_____/_____