



LEGACY PILATES, YOGA & MORE

1021 S 178 ST, STE 101, Omaha, NE 68118

402-502-9772

www.MindBodyPrograms.com

Vital programs to enhance your lifestyle.

CONFIDENTIAL HEALTH HISTORY FORM

THE FOLLOWING INFORMATION REQUESTED IS FOR GENERAL FITNESS PROGRAMMING AND IS IN NO WAY TO BE USED FOR DIAGNOSIS. WE RECOMMEND YOU VISIT YOUR PHYSICIAN PRIOR TO PARTICIPATING IN AN EXERCISE PROGRAM. VITAL LIFESTYLES, INC. HOPES TO ASSIST YOU IN YOUR PROCESS TOWARDS EXCELLENT HEALTH AND WELL-BEING. YOUR BODY'S ABILITIES, MOVEMENTS AND CHALLENGES ARE YOUR RESPONSIBILITY. WE SUPPORT YOU ON YOUR JOURNEY TO TOTAL WELLNESS AND GIVE YOU THE ATTENTION AND SUPPORT YOU DESERVE!

Name _____ Date of Birth _____

Address _____ Sex (circle one) M F

City _____ State _____ Zip _____

Phone (home) _____ (work) _____ (cell) _____

Email _____ Height _____ Weight _____

How did you find out about us? _____

To assist us with your postural analysis and exercise program, please answer the following questions.

1. What is your occupation?	
2. What are your hobbies?	
YES	
3. Do you:	
Sit many hours a day	
Stand in one position for a long period of time	
Carry things on one side of the body (purse, gym bag, children, groceries, etc.)	
Twist and turn the body	
Have other repetitive motions and/or behaviors (please list)	

4. Are you presently under professional medical care (such as physician, chiropractic, physical therapist, etc)?
 Yes No If yes, please explain _____

5. Does your physician know you are participating in an exercise program? Yes No

6. Has your physician advised you not to exercise? Yes No

7. Who is your primary physician?

Name _____ Phone _____

Address _____ Fax _____

8. Emergency contact person:

Name _____ Phone _____

10. How would you rate your eating habits? Poor Fair Good Excellent
11. Do you drink at least 36 oz. (~4 glasses) of water/day (**water**; not pop, coffee, juice, etc)? Yes No
12. What type of exercise/movement have you experienced?
 Dance Yoga Martial Arts Running Swimming Aerobics
 Weight Training Sports None Other _____
13. What are your fitness/wellness goals?
 Decrease Pain Enhance Flexibility/Range of Motion Weight Loss
 Weight Gain Enhance Athletic Performance Reduce Stress
 Weight Management Stress Management Increase Self Awareness
 Other _____
14. Are there any concerns we should know about you?

If you need information on these programs, check the boxes below:

- Pilates Mat Class Pilates Equipment Class Pilates Foundations Class Tai Chi
 Yoga Yoga Foundations Class Holistic Nutrition Reiki/energy management
 Massage Therapy Stress management Other _____
- What day(s) of the week is best for you? Mon Tue Wed Thu Fri Sat Sun
 What time(s) of the day are best for you? 6-8am 8-10am 10-Noon 12-4pm 5-9pm

Refer friends or family. You can earn credit towards your next training package. They must designate your name on their Health History Form when they register for and purchase a training or class package.

Name _____ **Email** _____
 Address _____ City _____ State _____ Zip _____
 Phone (home) _____ (work) _____

Name _____ **Email** _____
 Address _____ City _____ State _____ Zip _____
 Phone (home) _____ (work) _____

Name _____ **Email** _____
 Address _____ City _____ State _____ Zip _____
 Phone (home) _____ (work) _____

I understand that exercise can be hazardous and potentially dangerous. My trainer has not expressed or implied that this therapy is the primary treatment for any specific illness or disease. I understand that exercise is an adjunctive therapy that can be coordinated with the advice, treatment or prescriptions recommended by my regular physician. The decision to exercise is my own personal responsibility and discretion. In no way has Vital Lifestyles, Inc. and its associates, employees or contractors prescribed or diagnosed a treatment for my condition.

 Signature

 Date

WAIVER OF LIABILITY AND INFORMED CONSENT RELEASE

This release, Waiver of Liability and Informed Consent Release and Agreement, is made by and between the undersigned client _____ (client name) and Vital Lifestyles, Inc. and entered into on _____ (date) in connection with certain fitness and/or wellness programs to be provided by Vital Lifestyles, Inc., including, but not limited to, Pilates Training, Yoga, Tai Chi, Acupuncture, Resistance Training and Group fitness classes.

I recognize that Vital Lifestyles, Inc. will not provide the program to me without the execution of this instrument. I understand that Vital Lifestyles, Inc. specifically disclaims any liability for client’s individual use or application of information or techniques provided by Vital Lifestyles, Inc.

I acknowledge that Vital Lifestyles, Inc. is not associated with Pacific Springs Physical Therapy, in any way.

I assert that my participation in physical activity facilitated by Vital Lifestyles, Inc. whether in sessions, on the grounds, in transportation to or from the sessions, or at any other location is voluntary.

I further understand that there are serious inherent risks involved with all physical activity and that when performing exercise I may suffer minor injury, serious injury or even death. I understand these inherent risks and I assume all such inherent risks associated with participation in any activities with Vital Lifestyles, Inc. In consideration for participation in any session conducted by Vital Lifestyles, Inc., I, my heirs and assigns hereby release, discharge and waive, any and all claims, demands, losses or damages caused in whole or in part by Vital Lifestyles, Inc., its officers, directors, agents and employees, for any and all negligence by the Releases or otherwise. I will indemnify, save and hold harmless each of the Releases from any litigation expenses, attorney fees, loss, liability, damage, or cost which they may incur as a result of such claim.

I further represent that I am in good health and physical condition and that I am not disabled in any way, taking medication or suffering from any condition that would prevent my from safely engaging in such activities or that would make such participation potentially dangerous or harmful for me. I affirmatively assert that should I become disabled, begin taking medication or acquire any medical condition that could cause such participation to be dangerous or harmful to me, I will notify Vital Lifestyles, Inc. immediately, and cease all participation immediately. Should this occur, I agree that I will not return to participation in such potentially harmful activity without clearance from my physician.

I acknowledge that Vital Lifestyles, Inc. has not and will not render any medical services including medical diagnosis of my physical condition. I acknowledge that I either have no restrictions from my physician or that I have permission from my physician to participate in the fitness sessions with Vital Lifestyles, Inc.

I HAVE CAREFULLY READ, UNDERSTAND AND ACKNOWLEDGE ALL OF THE ABOVE STATEMENTS.

Client Name (please print)

Date

Client Signature

Phone number

Address

City, State. Zip

EMAIL Address _____

FOR MINORS ONLY (Under 18 years old)

The undersigned is a parent or legal guardian of _____ (client name) and on his/her behalf, hereby agrees to all the conditions set forth above.

Parent/Guardian Signature

Date

OFFICE ONLY

Witness

Date



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Physician Approval Form for Exercise

Dear: _____:

RE: Patient _____, DOB _____, Phone _____
wants to start an exercise program with us. **Your patient has disclosed specific health risk factors while completing our Health History Questionnaire.** The exercise program may involve core strengthening (abdominals, low back, gluteals, adductors), Pilates equipment with attached pulleys and springs, Yoga, Tai Chi, Breathing Practices Meditation, Weight Training, Prenatal Yoga and other fitness modalities. We teach these programs from a mindful, traditional perspective that **challenges the body in a gentle, yet progressive and powerful way.** Muscle endurance and strength, cardiorespiratory function and flexibility are improved through these approaches to exercise. **We challenge the body but, do not force or push it.**

We ask that you please provide your medical opinion and recommendations concerning his/her participation in an exercise program.

I approve and authorize this patient to take part in this exercise program while adhering to the following **recommendations or restrictions**:

I **APPROVE** and authorize this patient to take part in this exercise program.

I **DO NOT** approve and authorize this patient to take part in this exercise program.

Physician Name _____

Physician Signature _____

Address _____ City _____ State _____ Zip _____

Telephone _____ Fax Number _____

Please fax to 933-3163 or mail to the address above.

Thank you for your assistance~~Cindy Cook