Triumph Pilates & Neuro Studio

Client Intake Form

Date: _____

Client Information

- **Full Name:** _____
- **Date of Birth:** _____
- **Phone Number:** _____
- **Email Address:** _____
- **Emergency Contact (Name & Phone):** _____

Health & Medical Information

1. **Have you ever been diagnosed with any of the following?**
    - ☐ Heart condition
    - ☐ High blood pressure
    - ☐ Respiratory issues (e.g., asthma, COPD)
    - ☐ Osteoporosis / Osteopenia
    - ☐ Joint replacement
    - ☐ Neurological condition (e.g., Parkinson's, MS, Stroke)
    - ☐ Chronic back pain / spinal issues
    - ☐ Recent injury or surgery (last 12 months)
    - ☐ Other: _____

Lifestyle & Fitness

- **Have you practiced Pilates before?** ☐ Yes ☐ No
- **How often do you currently exercise?** ☐ Rarely ☐ 1–2x/week ☐ 3–5x/week ☐ Daily
- **Primary goals for starting Pilates (check all that apply):**
    - ☐ Improve strength
    - ☐ Increase mobility/flexibility
    - ☐ Pain management
    - ☐ Neurological support
    - ☐ Post-rehab / recovery
    - ☐ Stress relief/well-being
    - ☐ Other: _____

Waiver & Release of Liability

I acknowledge that I am voluntarily participating in Pilates and movement sessions at Triumph Pilates & Neuro Studio. I understand that Pilates involves physical activity, and as with any form of exercise, there are risks of injury or aggravation of existing conditions.

Disclaimer: I understand that Triumph Pilates & Neuro Studio and its instructors are not medical doctors, physical therapists, or licensed healthcare providers. The services provided are for fitness, movement, and wellness purposes only and are not intended to diagnose, treat, or cure any medical condition. I agree to consult my physician before beginning any exercise program and to follow their recommendations.

I accept full responsibility for my participation and any risks associated with it. I release, waive, and discharge Triumph Pilates & Neuro Studio, its owners, instructors, and employees from any and all liability, claims, or demands arising out of my participation in sessions.

I agree to immediately inform my instructor if I experience pain, dizziness, or discomfort during any session, and I understand that I am responsible for disclosing any medical or health information that may affect my participation.

By signing below, I confirm that I have read, understood, and voluntarily agree to the terms of this Waiver & Release of Liability.

Client Name: _____

Signature:_____

Date:_____