

SCARBOROUGH PHYSICAL THERAPY ASSOCIATES, P.A.

Exercise Studio Registration Form

Please list class you are registering for: _____ Day: _____ Time: _____

Last Name First Name M.I. Date of Birth

Mailing Address City State Zip

Home Telephone Work or Cell Phone Email address

Primary Care Physician Telephone # Person to Contact in Emergency Telephone #

How did you hear about us? _____

GOALS:

Why have you decided to take this class? Core Stability Flexibility Posture Strength
Stress Management Relaxation Other

Are there any additional goals that you are hoping to achieve? _____

LIFESTYLE:

What is your occupation? _____

Does your occupation involve any repetitive movements or prolonged postures? If so, please briefly explain.

What other sports, regular exercise, and/or hobbies are you involved in? _____

For those taking Yoga and Pilates, Have you participated in a Yoga or Pilates class in the past? _____

HEALTH QUESTIONNAIRE:

Please check (✓) all that apply. If applicable, please give further details.

____ Low Back Pain _____

____ Pelvic Pain _____

____ Neck Pain or Spinal Conditions _____

____ Any other Orthopaedic condition _____

____ Heart or blood pressure problems _____

____ Epilepsy (Grand mal seizures) _____

____ Are you pregnant? _____

If so, how many weeks pregnant are you? _____

Have you had any complications? _____

Do you have a history of falls? _____

If yes, when was the most recent fall? _____

Have you had any recent injuries or surgery? _____

If yes, please give details and date(s) _____

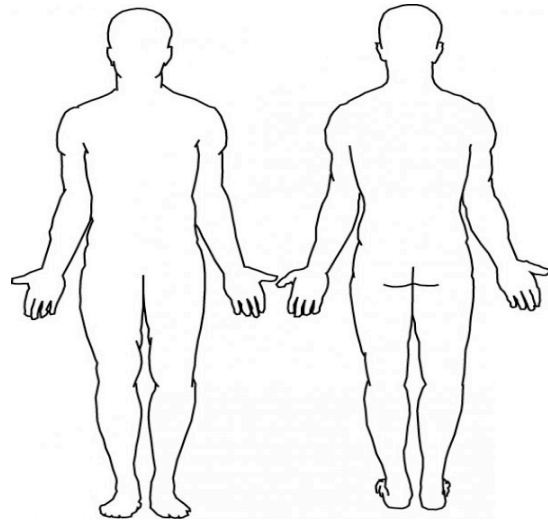
Any other conditions (arthritis, asthma, cancer, diabetes, depression, dermatitis, other?) _____

Are you currently taking any medication? *If so, please list:* _____

Do you have any allergies: Yes ____ No ____ *If so, please list:* _____

In the event of an emergency, which hospital would you prefer to go? _____

Please mark area of pain in picture:



Please describe pain: _____

Rate pain using a 0-10 scale _____

PLEASE SEE OTHER SIDE

SCARBOROUGH PHYSICAL THERAPY ASSOCIATES, P.A.

51 U.S. Route One, Suite J, Scarborough, ME 04074

Telephone (207) 883-1227

Fax (207) 883-6199

Liability Waiver

I/we realize that participation in Scarborough Physical Therapy Associates' exercise studio and activities could involve some possible personal injury. Despite precautions, accidents and injuries may occur. By signing this release form, I/we (the participant, parent/guardian and our heirs and assigns) assume all risks related to the activities and spaces used by Scarborough Physical Therapy Associates.

I/we recognize this it is my/our responsibility to notify my Instructor of any serious illness or injury before every class. As a result, I agree not to perform any exercises/postures to the extent that they cause me strain or pain.

I/we understand that it is my/our responsibility to consult with a physician prior to and regarding my participation in this class. As a result, I represent and warrant that I am physically fit and I have no medical condition that would prevent my full participation in class.

I/we agree to release and hold harmless Scarborough Physical Therapy Associates, including it's Physical Therapist Instructors, staff, members and facilities used from any cause of action, claims, or demands now and in the future. I/we will not hold Scarborough Physical Therapy Associates liable for any personal injury or any personal property damage, which may occur on the premises before, during, or after activities related to same.

My Doctor has not limited my participation in any exercise due to any medical conditions including but not limited to cardiac or orthopedic conditions.

Payment is due prior to the start of each Class Session or "Drop-In" class

I have read the above release and waiver of liability and fully understand its contents. I voluntarily agree to the terms and conditions stated above.

Participant Name: _____
Please Print

Participant Signature: _____ Date: _____

For Minors, under the age of 18:

Name of Representative: _____
Please Print

Relationship to Participant: _____

Signature of Representative: _____ Date: _____

I have received and understand the Studio Information Sheet. _____
Initials of Participant or Responsible Party