

Today's Date: \_\_\_\_\_



### Bria Pilates Personal History Form

*Please be advised that all information is kept strictly confidential.*

#### CLIENT INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Business/Cell phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Do you wish to receive e-mail confirmation of your appointments?  Yes  No

Date of Birth: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Employment Status:  Employed  Full-time  Part-time  Restricted Duty  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

#### CURRENT PHYSICIAN

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Address: \_\_\_\_\_

#### OTHER...

Why did you choose to train at Bria instead of another organization? *check all that apply*

Location  Personal Trainers  Cost  Customer Service  Word of Mouth  
 Programs  Other \_\_\_\_\_

How far do you live from our training studio? \_\_\_\_\_ miles

How did you hear about Bria? \_\_\_\_\_

Which newspaper(s) do you read? \_\_\_\_\_

Which radio station(s) do you listen to? \_\_\_\_\_

Which local magazine(s) do you read? \_\_\_\_\_

Which local morning TV show do you watch? \_\_\_\_\_

What would cause you to discontinue training with Bria?  
\_\_\_\_\_

Client Name: \_\_\_\_\_

**HEALTH HISTORY**

	YES	NO
Have you had surgery in the last 6 months? If yes, describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you been pregnant? Given birth how many times? _____ Cesarean Births? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke? If yes how much/often? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol? If yes how much/often? _____	<input type="checkbox"/>	<input type="checkbox"/>

Check if you currently have or previously had the following medical conditions:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> High/Low blood pressure |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Arthritis               | <input type="checkbox"/> High cholesterol        |
| <input type="checkbox"/> Heart condition     | <input type="checkbox"/> Current pregnancy       | <input type="checkbox"/> Allergies               |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Dizzy spells            | <input type="checkbox"/> Cancer                  |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> Hernia                  |
| <input type="checkbox"/> Recent Surgery      | <input type="checkbox"/> History of Seizures     | <input type="checkbox"/> Osteoporosis            |
| <input type="checkbox"/> Bone/Joint disorder | <input type="checkbox"/> Joint replacement _____ | <input type="checkbox"/> Medications             |

Medication: _____	Dose: _____	Condition: _____
Medication: _____	Dose: _____	Condition: _____
Medication: _____	Dose: _____	Condition: _____

Have you injured any of the following? *check all that apply*

- |                                   |                                |                                       |
|-----------------------------------|--------------------------------|---------------------------------------|
| <input type="checkbox"/> Neck     | <input type="checkbox"/> Elbow | <input type="checkbox"/> Upper back   |
| <input type="checkbox"/> Wrist    | <input type="checkbox"/> Knee  | <input type="checkbox"/> Lower back   |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Hip   | <input type="checkbox"/> Other: _____ |

How would you rate your level of stress on a daily basis?

- Low             Moderate             High

How would you rate your general health?

- Unhealthy             Average Health             Very Healthy

Estimate how many hours of sleep you get each night: \_\_\_\_\_

What position are you in while working?  Standing     Sitting     Walking     Bending  
 Lifting # lbs \_\_\_\_\_ Frequency \_\_\_\_\_  Other \_\_\_\_\_

Have you undergone or are you currently undergoing:

- Physiotherapy     Chiropractic     Massage Therapy     Acupuncture  
 Physical Therapy     Other \_\_\_\_\_ If yes why? \_\_\_\_\_

Client Name: \_\_\_\_\_

**EXERCISE HISTORY**

What is your current exercise level?

None

2-3 times per week

4-5 times per week

Please describe: \_\_\_\_\_

Are there any activities you can't do now as a result of injury? \_\_\_\_\_  
\_\_\_\_\_

Have you had any past training in Pilates?  Yes  No

If yes when and where? \_\_\_\_\_

When were you in the best shape of your life? \_\_\_\_\_

Have you been exercising consistently for the past 3 months?  Yes  No

When did you first start thinking about getting in shape? \_\_\_\_\_

What if anything stopped you in the past? \_\_\_\_\_

On a scale of 1-10, how would you rate your present fitness level (1=Worst 10=Best)? \_\_\_\_\_

**PERSONAL GOALS**

Number the following exercise benefits according to their importance for you.

(1=most important, 10= least)

Weight Loss \_\_\_\_\_ Weight Gain \_\_\_\_\_ Stress Reduction \_\_\_\_\_

Increase Flexibility \_\_\_\_\_ Increase Strength \_\_\_\_\_ Posture \_\_\_\_\_

Spinal Rehabilitation \_\_\_\_\_ Cardio Conditioning \_\_\_\_\_

What are your specific goals for Pilates? \_\_\_\_\_  
\_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Client Name: \_\_\_\_\_

## Client Agreement

Payments: For your convenience and our protection it is Bria's policy to keep a current credit card on file for all clients. This allows you to use our online scheduling system, maintain an active and on-going wellness plan, book appointments, hold preferred appointment slots, make purchases by phone for gifts or self, and utilize our overall services. You are not required to put all Bria purchases on this card. You are welcome to pay for your products and services with cash, check, or another credit card as well.

Forms: You will complete and sign a Health History form, Liability Waiver, Client Agreement, and other necessary forms prior to the commencement of any session. Forms and files are updated annually and/or as needed.

Rates: Session rates are posted and are subject to change periodically. Please watch for postings and updates via in-studio signs and emails.

Punctuality: Sessions will begin at scheduled times and run for the duration of the appointment. You are expected to arrive on time for your appointments. Arriving late will decrease the length of your session.

Cancellation: Because of our private and small group approach and also because of session length and demand for services at Bria we respectfully require 24 hours notice when canceling or rescheduling Pilates and Personal Training sessions. We require 48 hours notice for changing or canceling Physical Therapy/Massage Therapy appointments. If proper cancellation notice is not received, for Pilates and personal training, you will be charged for the reserved session. In the case of Physical Therapy and Massage a standard \$60 fee is applied to late canceled appointments.

Sales: All sales are final. Memberships and multi-session packages are non-transferable. Memberships renew automatically per agreement. Packages expire 90 days from the date of purchase.

Scheduling: Group classes, private Pilates and personal training sessions may be scheduled online using our web based scheduling system via [www.briaseattle.com](http://www.briaseattle.com) Appointments for Physical Therapy, Therapeutic Massage, Workshops, and other services including Pilates can be scheduled in person or by phone (206) 781-4576. Any and all cancellations must be made in person or by phone or email. The web-based scheduling system does not allow you to cancel an appointment online; you must call to cancel and appointment.

I understand and agree to the policies stated above.

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Client Signature

Date

Client Name: \_\_\_\_\_

# Bria Pilates and Physical Therapy

## LIABILITY

I am participating physical activity at Bria Pilates and Physical Therapy which may include, but it not limited to Pilates. I recognize that any physical activity may be strenuous and may cause injury, and I am fully aware of the risks and hazards involved in such activity, and assume full responsibility for these risks.

I knowingly, voluntarily, and expressly waive any claim I may have against Bria Pilates and Physical Therapy for injury or damages that I may sustain as a result of participating in these activities.

Myself, my heirs, and legal representatives forever release from liability, waive, discharge, and covenant not to sue Bria LLC, Bria studio, Bria's owners and its agents for any injury or death caused by any negligent act or omission.

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

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Participant Signature

Date

## CREDIT CARD ON FILE AGREEMENT AND AUTHORIZATION

In consideration of Bria, its practitioners, and the integrity of my wellness plans I agree to and authorize Bria to keep my credit card on file. I understand that it is my responsibility to keep my account up to date and pre-paid. If I have not pre-paid for a class or session, I recognize that I will be responsible for payment immediately, and I authorize Bria to charge my credit card on file for unpaid sessions.

Last Four Digits of Credit Card Number: \_\_\_\_\_

Three digit code from back of card: \_\_\_\_\_

By signing below I authorize Bria to store and charge my credit card listed above for unpaid session fees.

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Client Signature

Date

## CANCELLATIONS

We respectfully require at least 24 hours notice of cancellations and schedule changes. For Physical Therapy/Massage Therapy appointments we require 48 hours notice or changes or cancellations. By signing below I authorize Bria to charge my credit card on file for late cancellations or schedule changes as stated on my client agreement form.

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Client Signature

Date

Client Name: \_\_\_\_\_