POLESTAR PILATES POST-PREGNANCY PILATES CLASSES – PERSONAL DETAILS	
Name:	**Today's date:**
Address:	**Postcode:**
Occupation:	**Your date of birth:**
Email:	**Phone:**
Emergency contact (and phone number):	

Please note:
If you had your child less than 6 weeks ago you need to seek you doctor's approval prior to commencing Pilates. If you still have some form of diastasis recti (abdominal separation) then please discuss this with your instructor so we are able to provide the best care possible.

Have you attended a Pilates class before?	**Yes**		**No**		**If YES approx. how many?**	
What type of Pilates have you practiced? Mat, Studio, Reformer, other					**How long has it been since you practiced Pilates?**	
What forms of exercise have you completed since the birth of your child?						
How often have you exercised after the birth of your child?						
How soon did you start exercising after the birth of your child?						

PREGNANCY						
Have you recently given birth?	**Yes**		**No**		**If YES how many weeks ago?**	
Did you have diastasis recti (abdominal separation)	**Yes**		**No**		**Was this delivery vaginal and/or by caesarean?**	
Was this your first Pregnancy?	**Yes**		**No**		**If not, how many other children have you had?**	
If No, when was your last Pregnancy and were there any complications?					**Were your previous deliveries vaginal and/or caesarean**	
Are you currently on any medication	**Yes**		**No**		If yes please list	

MEDICAL HISTORY					
As with any exercise program your safety is the main priority. Please complete the below list of medical history and ask your doctor to give you the all clear if any of these conditions apply. Polestar Pilates instructors may ask you to obtain medical clearance for Pilates if they have any concerns about your safety during classes or sessions.					
HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING:					
Arthritis	**Yes**		**No**		
Asthma	**Yes**		**No**		
Allergies	**Yes**		**No**		
Chest Pains / Palpitations	**Yes**		**No**		
Cancer	**Yes**		**No**		
Diabetes	**Yes**		**No**		
Epilepsy	**Yes**		**No**		

HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING:					
Fainting / Dizziness	**Yes**		**No**		
Glaucoma	**Yes**		**No**		
Hypertension	**Yes**		**No**		
Hernia	**Yes**		**No**		
Heart Disease	**Yes**		**No**		
Joint replacements	**Yes**		**No**		
Low blood pressure	**Yes**		**No**		
Liver or Kidney condition	**Yes**		**No**		
Osteoporosis	**Yes**		**No**		
Raised Cholesterol	**Yes**		**No**		
Stroke	**Yes**		**No**		
DO YOU HAVE ANY MUSCULOSKELETAL INJURIES OR PAIN THAT MY LIMIT YOUR MOVEMENT?					
Neck	**Yes**		**No**		
Shoulder	**Yes**		**No**		
Elbows	**Yes**		**No**		
Wrists	**Yes**		**No**		
Lower Back	**Yes**		**No**		
Upper Back	**Yes**		**No**		
Hips	**Yes**		**No**		
Knees	**Yes**		**No**		
Ankles	**Yes**		**No**		
Feet	**Yes**		**No**		
ANY OTHER HEALTH ISSUES WE SHOULD KNOW ABOUT?					

WAIVER

Please note: Your participation in this Post Pregnancy Pilates Class assumes that you have received medical clearance from your doctor.

I understand that I participate in Pregnancy Pilates classes at my own risk. I acknowledge that, prior to the commencement of Pilates classes I must disclose any health conditions and obtain clearance from my doctor for those conditions. I take it upon myself to discuss any changes in my health with my Pilates teacher. I recognize that the teacher is not able to provide me with medical advice with regard to my medical fitness and that the information provided is used as a guideline to the limitations of my ability to exercise.

Cancellation Policy: If I need to cancel a class, I agree to give 24 hours' notice, otherwise I understand that this will result in a loss of non-refundable session. **Expiry**: All class packages have an expiry of 3 months.

Signature: **Today's Date:**

Print Name: