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Indemnity Form

PERSONAL DETAILS

Name: _____ Surname: _____

Identity number: _____ Referred by: _____

Address: _____

Contact number: _____

Email address _____

Date of birth: _____ Occupation: _____

Next of kin:

Name: _____ Surname: _____

Contact number: _____ Relationship: _____

INDEMNITY

I, _____, acknowledge that I have agreed to undergo the assessment of my health and fitness, and to accept the exercises prescribed for me by NOVA Pilates at my own risk. I hereby indemnify the studio's owner and the independent contractors in respect of any liability arising from my participation in assessment tests and exercises, whether as a result of injury, illness or otherwise, and in particular any claims or damages from any person whatsoever. I also indemnify them from any loss or damage on property inside the studio and in the business park.

SIGNED AT _____ ON THE _____ DAY OF _____ 20__

Signature

Assessment Form

Medical history:

Do you have any heart trouble or defect?	Yes	No	
Do you have arthritic joints/bone/joint problems?	Yes	No	
Any operations or major injuries in the last year?	Yes	No	
Are you trying to get pregnant/is pregnant/had a baby in the last 6 months?	Yes	No	
Do you suffer from back pain?	Yes	No	
Have you been given remedial exercises for any condition?	Yes	No	
Regular dizziness/feeling faint?	Yes	No	
Do you smoke?	Yes	No	
Blood pressure	High	Low	Normal
Do you suffer from	Epilepsy	Asthma	Diabetes

If you have answered yes to any of the above or want to give any additional information please explain below

Lifestyle:

Does your occupation or physical activities involve:

Sitting for long periods	Yes	No
Standing for long periods	Yes	No
Driving for long periods	Yes	No
Bending	Yes	No
Lifting heavy objects	Yes	No
Repetitive action	Yes	No

If you have been referred by a specialist practitioner please provide their name and contact number

General:

Do you have prior Pilates experience? State period and level:

What are your aims, expectations and achievements in doing Pilates?

Additional notes:
