



## Physician Release for Participation at Whole Pilates Studio

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

Please indicate the type of fitness class or program the client will be participating in at Whole Pilates Studio:

\_\_\_\_ Pilates Mat Classes  
\_\_\_\_ Pilates for Multiple Sclerosis  
\_\_\_\_ MS Moves & Dance  
\_\_\_\_ Pilates for Strong Bones & Balance  
\_\_\_\_ Private/Semiprivate Pilates Equipment  
Other: \_\_\_\_\_

Please check if the client has any conditions which could affect participation during this program:

\_\_\_ Arthritis  
\_\_\_ Dizziness/Vertigo  
\_\_\_ Heart Attack  
\_\_\_ Back Pain  
\_\_\_ History of Falls/Loss of Balance  
\_\_\_ High/Low Blood Pressure  
\_\_\_ Herniated Disc  
\_\_\_ Lack of coordination with walking  
\_\_\_ Cancer  
\_\_\_ Spinal Stenosis  
\_\_\_ Diabetes  
\_\_\_ Acid Reflux/GERD  
\_\_\_ Numbness/tingling in arm/leg  
\_\_\_ Hyper/hypoglycemia  
\_\_\_ Thyroid Disorder  
\_\_\_ Pelvic Pain  
\_\_\_ Neurological disease  
\_\_\_ Joint Replacement  
\_\_\_ Osteopenia/Osteoporosis  
\_\_\_ Hearing Problems  
\_\_\_ Pregnancy  
\_\_\_ Recommended restriction of movement from a Healthcare Practitioner (e.g., lifting/bending/arching/rotation)

Please explain any checked areas and list any other injury/illness that could impact participation in exercise: \_\_\_\_\_  
\_\_\_\_\_

This client is released to participate in a specialized fitness program at Whole Pilates Studio. By signing this release I agree that my client is ready to participate in an exercise program suitable to the needs of my client. If any condition arises that would prohibit the client from further participating in such a program, it is the responsibility of the client and/or the physician to promptly communicate with the Whole Pilates Instructor.

**Name of Practice/Clinic:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_