



Pre Natal - New Client Registration

Name: _____ Date: _____

Address: _____

Phone: _____ Email: _____

Emergency Contact: _____ Phone: _____

Who referred you to Whole Pilates? | How did you hear about us?

Number of pregnancies _____

Number of c-sections _____

Number of vaginal births _____

What trimester is your current pregnancy? 1st 2nd 3rd

What level of activity are you currently doing? Low Medium High

Are you experiencing any of the following: YES (circle below) NO

Vaginal Bleeding

Swelling

Extreme Nausea

Frequent Uterine contractions

Are you experiencing any pain or discomfort in the following areas

Low Back

Ribcage

Groin/Pubic

Wrist

Pelvic Floor

Neck

Leg

Other: _____

Abdominals

Have you experienced or do you presently have any of the following conditions:

High or Low Blood Pressure

Incompetent Cervix

Pre-eclampsia

Prolapse

Abdominal Diastasis

WHOLE PILATES STUDIO: Terms of Service and Release of Liability

These Terms of Service form a legal agreement between Spirit of Health KC, LLC, d/b/a Whole Pilates Studio (“**Whole Pilates**”), and the individual completing a registration for Pilates services whether in-person or at www.wholepilatesstudio.com (hereafter, “**I**”, “**me**”, “**my**”), and regardless of whether the Pilates services are delivered in-person or via any downloadable software program that I am accessing or installing on my device or personal computer and the services available through that software program.

1. I understand that the process of doing Pilates may involve dialog, questions regarding my history, previous injuries, current status, etc., and that my clear and complete responses to these questions will determine the quality and safety of the exercises.
2. I understand that Pilates involves unique equipment that I may not be familiar with; that the equipment is constructed of moving parts, springs, and levers; and that the movement of my body and the apparatus could result in the possibility of falling or being trapped by the moving parts. I understand that my clear and focused involvement is necessary for my physical improvement and safety.
3. I understand that my participation may require the instructor to move me or ask me to move my body in ways that are new to me, and it is possible that in these movements pain or injury may occur or be exacerbated. I understand that it is my responsibility to communicate clearly and promptly with my instructor, telling the instructor of any pain, discomfort, medical findings, or physical limitations. I understand that it is my responsibility to stop any movement or exercise that I feel is too much for me or may cause me pain or injury.
4. I understand that it is my sole responsibility to consult with a physician prior to my participation in Pilates to determine my fitness level and safety of participation. I represent and warrant that if I have recently experienced a new injury or illness, if I am or may be pregnant, if I am post-partum, or if I have concerns of osteoporosis, multiple sclerosis or other significant neurological or physical dysfunction, I have consulted with my physician and obtained my physician’s approval for participating in Pilates.
5. I recognize and understand that there are risks of physical injury inherent in participation in any physical exercise program and that those risks are increased with the use of exercise equipment, particularly the unique equipment used in Pilates instruction. I also understand that exercise equipment, particularly the moving parts, may be subject to fatigue or other wear and tear that may not be readily apparent to the user or to the Pilates studio. I **KNOWINGLY ASSUME THE RISKS INVOLVED IN TAKING PILATES INSTRUCTION (WHETHER IN-PERSON OR ONLINE) AND USING PILATES EQUIPMENT.**
6. I represent and warrant that I am at least 18 years of age. Alternatively, I agree that if I am under 18 years of age, I will disclose my age to Whole Pilates and have my parent or legal guardian sign a release form.
7. I understand that any audio or video recording of Pilates sessions is strictly prohibited unless expressly agreed to in writing by Whole Pilates. I promise and agree that I am using the Pilates services for my own personal, noncommercial purposes and will not redistribute and transfer the services to anyone else. I agree that I will not provide my password or other account information to anyone else or knowingly allow someone else to use my password or other account information to access the services.

8. IN FURTHER CONSIDERATION FOR MY PARTICIPATION IN THE PILATES SERVICES, I KNOWINGLY, VOLUNTARILY AND EXPRESSIVELY WAIVE AND RELEASE ANY CURRENT OR FUTURE CLAIM I MAY HAVE AGAINST WHOLE PILATES, ITS EMPLOYEES, SHAREHOLDERS, CONTRACTORS, INSTRUCTORS, DIRECTORS, OFFICERS, AGENTS, SUCCESSORS AND ASSIGNS (THE "RELEASEES") ARISING OUT OF OR ATTRIBUTABLE TO MY PARTICIPATION IN THE PILATES CLASSES, WHETHER ARISING OUT OF THE NEGLIGENCE OF WHOLE PILATES, OR ANY RELEASEES OR OTHERWISE. I COVENANT NOT TO MAKE OR BRING ANY SUCH CLAIM AGAINST WHOLE PILATES, OR ANY OTHER RELEASEE, AND FOREVER RELEASE AND DISCHARGE WHOLE PILATES, AND ALL OTHER RELEASEES FROM LIABILITY UNDER SUCH CLAIMS.
9. These Terms of Service and any dispute or controversy arising out of or related thereto ("Claims") shall be governed by and construed, interpreted and resolved in accordance with the laws of the State of Missouri without regard to its choice of law provisions; provided, however, that any procedural or substantive Claim conflicting with or falling under the exclusive jurisdiction of United States federal law shall be governed by, and construed, interpreted and resolved in accordance with United States federal law without regard to its choice of law provisions. All Claims shall be submitted exclusively to the federal and state courts of competent jurisdiction located in Kansas City, Missouri, and the parties hereby unconditionally and irrevocably consent and submit to such exclusive jurisdiction and venue and waive any objection they may now or hereafter have with respect thereto.

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

SPIRIT OF HEALTH THERAPIES: Release and Waiver of Liability

The individual named below ("**I**" or "**me**") desires to participate in one or more therapy sessions provided by Spirit of Health KC, LLC, d/b/a Spirit of Health ("**Spirit of Health**"), a Missouri limited liability company, which may include, but is not limited to, one or more of the following forms of therapy: Far Infrared Sauna, iMRS, Lymph Vibra Therapy, True Rife, Ionic Detox Foot Bath, or any other forms of therapy provided by Spirit of Health. As lawful consideration for being permitted by Spirit of Health to participate in the Sessions and the intangible value that I will gain by participating in the Sessions, I agree to all the terms and conditions set forth in this agreement (this "**Agreement**").

Services Disclaimer. I understand and realize that Vaughn Lawrence and Mike Casey are lay natural health advisors, and NOT medical doctors or licensed physicians. I understand that the Sessions are in no way medical treatments nor are they intended to diagnose, treat, prescribe, advise or cure any condition. I understand that the Sessions do not guarantee any particular health-related results. I understand that the Sessions cannot determine specific disease conditions I may or may not have and do not replace the diagnostic services offered by a licensed physician.

Assumption of Risk. I am aware of and understand the risks inherent in the use of the particular therapy utilized during the Sessions. I VOLUNTARILY ASSUME THE RISK OF INJURY, ACCIDENT, OR DEATH WHICH MAY ARISE FROM THE USE OF THE PARTICULAR THERAPY UTILIZED DURING THE SESSIONS. I acknowledge that I am voluntarily participating in the Sessions with knowledge of the potential danger involved and hereby agree to accept and assume any and all risks of injury, accident or death, whether caused by the negligence of Spirit of Health or otherwise. I further acknowledge that I have received and read through the instructions and warnings related to the particular therapy utilized during the Sessions.

Liability Release. IN FURTHER CONSIDERATION FOR MY PARTICIPATION IN THE SESSIONS I KNOWINGLY, VOLUNTARILY AND EXPRESSLY WAIVE AND RELEASE ANY CURRENT OR FUTURE CLAIM I MAY HAVE AGAINST SPIRIT OF HEALTH, ITS EMPLOYEES, SHAREHOLDERS, CONTRACTORS, INSTRUCTORS, DIRECTORS, OFFICERS, AGENTS, SUCCESSORS AND ASSIGNS (THE “**RELEASEES**”) ARISING OUT OF OR ATTRIBUTABLE TO MY PARTICIPATION IN THE SESSIONS, WHETHER ARISING OUT OF THE NEGLIGENCE OF SPIRIT OF HEALTH OR ANY RELEASEES OR OTHERWISE. I COVENANT NOT TO MAKE OR BRING ANY SUCH CLAIM AGAINST SPIRIT OF HEALTH OR ANY OTHER RELEASEE, AND FOREVER RELEASE AND DISCHARGE SPIRIT OF HEALTH AND ALL OTHER RELEASEES FROM LIABILITY UNDER SUCH CLAIMS. I also understand that any foods or supplements I choose to consume, or any natural therapies I choose to pursue are at my own discretion, of my own free will and at my own risk. I also understand that all third-party information in the form of fliers, pamphlets and articles received by me are for informational and educational purposes only, and do not necessarily reflect the viewpoints of Spirit of Health. I further acknowledge and agree all waivers, releases and covenants made herein are binding on me, my family, estate, heirs or legal representatives.

I further acknowledge that it is my responsibility to contact and consult with my primary care physician before starting or engaging in any natural health program, diets, supplements, or therapies. I will not discontinue, change or alter any medications or therapies that have been prescribed for me by a physician without first consulting the prescribing physician. I certify that I am participating in the Sessions and all further communication with Spirit of Health, whether in person, or by mail, telephone, email, text message, video conference or any other form electronic communication, solely on my own behalf and not as an agent or representative of any federal, state, county, or local government or private agency on a mission of investigation.

This Agreement constitutes the sole and entire agreement of Spirit of Health and me with respect to the subject matter contained herein and supersedes all prior and contemporaneous understandings, agreements, representations, and warranties, both written and oral, with respect to such subject matter. If any term or provision of this Agreement is invalid, illegal, or unenforceable in any jurisdiction, such invalidity, illegality, or unenforceability shall not affect any other term or provision of this Agreement or invalidate or render unenforceable such term or provision in any other jurisdiction. This Agreement is binding on and shall inure to the benefit of Spirit of Health and me and their respective successors and assigns. All matters arising out of or relating to this Agreement shall be governed by and construed in accordance with the internal laws of the State of Missouri without giving effect to any choice or conflict of law provision or rule. Any claim or cause of action arising under this Agreement may be brought only in the federal and state courts located in Jackson County, Missouri, and I hereby consent to the exclusive jurisdiction of such courts.

Consent. I have carefully read, fully understand and agree to the terms of this Agreement.

Print Name: _____

Signature: _____ **Date:** _____

**(Parent/guardian sign if under 18)*



Payment & Cancellation Policy

Cancellations and rescheduling must be done 24 hours prior to the class or appointment start time. No-shows or less than 24-hour notice will be charged for any missed sessions. Any cancellation and/or rescheduling after the 24 hour window will be considered a "Late Cancel". A Late Cancel informs the instructor of the late cancellation but will still forfeit the session and charge the account.

I have read and voluntarily agree to the terms and conditions stated above.

Signature: _____ **Date:** _____



Physician/Midwife Release for Participation in Pre-Natal Pilates Program

The Whole Pilates Pre-Natal Program is designed to cater to the pregnant woman throughout the three trimesters and assist the body in preparing for labor and delivery. The principles of our program are based on the Center for Women's Fitness Pre & Postnatal Pilates Program as well as our background in physical therapy to provide the most current research based approach. The program consists of low-impact strengthening and flexibility to help keep proper body alignment and pelvic function that can protect the mother's body during pregnancy and assist in positioning the baby into an ideal birth alignment. The class will also offer the client educational materials related to promoting techniques that aid in natural childbirth.

If the client experiences any of the following while participating in the Pre-Natal Program, it is the clients responsibility to immediately inform the instructor: dizziness, blurred vision, gushing of fluid from the vagina, vaginal bleeding, sudden pain, pubic or pelvic floor discomfort, an abnormal increase in uterine contractions, or prolonged periods of decreased fetal movement.

Client Name: _____

Client Signature: _____ **Date:** _____

This client is released to participate in the Pre-natal Pilates Program at Whole Pilates Studio. By signing this release I agree that my client is ready to participate in a program specific to the needs of the pre-natal woman. If any condition arises during pregnancy that would prohibit the client from participating in such a program, it is the responsibility of the client and/or the physician/midwife to promptly communicate with the Whole Pilates Instructor.

Conditions which could affect participation during this program include: (circle below)

High or Low Blood Pressure

Abdominal Diastasis

Placenta Previa

Incompetent Cervix

Pre-eclampsia

Prolapse

Name of Practice/Clinic: _____ **Phone:** _____

Physician/Midwife Name: _____ **Date:** _____

Physician/Midwife Signature: _____