



REGISTRATION FORM
(Please Print Clearly)

For most people, Yoga should not pose any problem. With this registration, we can identify participants for whom this physical activity should have medical advice concerning its appropriateness for them.

Please read each question carefully and check the YES or NO opposite the question as it applies to you. Please answer these questions as accurately as possible in order to assist *Breathing Space Yoga & Wellness Services* deliver a program that suits your needs as much as possible.

The confidential information on this registration is provided to the staff at *Breathing Space Yoga & Wellness Services* only. By accepting this registration, the staff agrees that the information contained herein will not be disclosed to others.

FULL NAME: _____ **Mobile Phone:** _____

ADDRESS: _____ **Home Phone:** _____

City: _____ **Postal Code:** _____

E-MAIL: _____ **Occupation:** _____

DOB: _____ (Birthday is for the purposes of a medical emergency, should emergency personnel be called)

Emergency Contact: _____ **Telephone:** _____

How did you find out about Breathing Space Yoga & Wellness Services?

1. Do you have high blood pressure? YES____ NO____

2. Do you have low blood pressure? YES____ NO____

3. Do you have heart problems? YES____ NO____

If yes, give details here:

4. Do you have thyroid problems? YES____ NO____

5. Do you have a hernia? YES____ NO____

If yes, give details here:

6. Do you have osteoarthritis or other form of arthritis? YES____ NO____

If yes, give details as to where:

7. Has your doctor ever told you that you have a bone or joint problem (for example: back, neck, knee, elbow, wrist, ankle, arthritis, etc.) that can be aggravated by exercise or might become worse with exercise? If yes, please specify:

8. Do you suffer from depression? YES____ NO____



Breathing Space Yoga

& Wellness Services

9. Do you have problems sleeping? YES _____ NO _____
10. Do you suffer from cataracts, glaucoma, or other eye condition? YES _____ NO _____
11. Are there any physical conditions that restrict you physically which the instructor needs to know? An example would be an old injury, whiplash injury, fibromyalgia, lupus, chronic fatigue syndrome, or multiple sclerosis. If yes, please give details:

12. Are you presently pregnant? YES _____ NO _____
13. Did you have a baby recently? YES _____ NO _____
If yes, when: _____
14. Have you had a surgery recently? YES _____ NO _____
15. Do you have a lung condition? YES _____ NO _____
If yes, please specify:

16. Are you presently suffering a cold, flu, asthma, or other common ailment? If yes, please specify:

17. Have you taken yoga, meditation, pilates, or other stress management techniques before?
YES _____ NO _____ If yes, please specify for how long and where.

18. What do you expect from this class or workshop?

There may be contact between the teacher and a student in the form of hands on assisting. If you prefer not to be touched, please inform your teacher.

If you answered YES to one or more of the above health related questions please discuss it with the teacher before starting the class.

Please print and fill out this form before coming to class if possible. Please give this filled out form to the teacher before the start of the class. Thank you.

DATE: _____