



Registration Form for Yoga Classes

Day:

Time:

| | | | |
|--|--|--------------------------------|--|
| Name: | | | |
| Address: | | | |
| Phone no: | | | |
| Email: | | | |
| Emergency contact: Name: | | | |
| Phone no: | | | |
| Confidential medical questionnaire – so that we can teach you safely Please tick alongside and <u>give further details overleaf</u> | | | |
| Allergies/ Asthma | | High/Low Blood Pressure | |
| Arthritis or Rheumatism | | Injuries | |
| Anxiety or Panic Attacks | | Joint Problems (specify) | |
| Cancer | | Major Illness or Surgery | |
| Circulatory Problems | | Menieres Disease | |
| Depression or history of | | Migraines/Headaches | |
| Detached Retina | | Multiple Sclerosis (MS) | |
| Diabetes Type 1 or Type 2 | | Myalgic Encephalomyelitis (ME) | |
| Epilepsy | | Pregnant | |
| Frequent Nose Bleeds | | Skin Conditions | |
| Given birth within 3 months | | Thyroid Problems | |
| Heart Condition | | Varicose Veins | |

Have you done yoga before? **Yes/No** If yes, for how long?

Where did you hear about the iYoga Centre?

Please circle YES if you wish to receive emails about classes and events at the iYoga Centre

Signed:

Date: