Registration Form

Name:	
Address:	
Phone no:	
Email:	
Emergency contact: Name: Phone no:	

Confidential medical questionnaire – so that we can teach you safely
PLEASE TICK AND PROVIDE DETAILS OVERLEAF

Allergies/ Asthma		High/Low Blood Pressure	
Arthritis or Rheumatism		Injuries	
Anxiety or Panic Attacks		Back/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*** TO RECEIVE EMAILS ABOUT TIMETABLE CHANGES, CLASSES AND WORKSHOPS AT THE IYOGA CENTRE.

Signed: **Date**: