MEDICAL HISTORY FOR YOGA THERAPY

Name: ____ Birthdate: __________________

Address: ____PC:_____________

Phone: __________________________ E-mail : ____

EMERGENCY CONTACT: ____

Occupation: ___________________________________ STRESS LEVEL (1-10) ________

My main health concern is ____

This condition began ____

It is aggravated by ____

Major surgery/accidents ____

My energy level is ____

To relax, I ____

My regular exercise includes ____

Previous yoga experience: ____

How do I expect to benefit from yoga? ____

THE FOLLOWING APPLY TO ME:

___ Cancer

___ Active Rheumatoid Arthritis

___ Osteoarthritis

___ Heart Condition

___ Circulatory Disorder

___ Varicose Veins

___ Pregnancy-due date-

___ Asthma

___ Kidney/urinary problems

___ Epilepsy

___ High/Low Blood Pressure

___ Diabetes

___ Headaches

___ Allergies

___ PMS

___ Digestive Problems

___ Surgical Implants

___ Medications____________________________________

____

___ Homeopathic Remedy

___ Chiropractic Treatment

___ Irregular Sleeping Patterns

___ Unexplained symptoms: dizziness, nausea anxiety or____

___ Other conditions____

*I, the undersigned, am attending yoga therapy classes at **Centerpoint Yoga Therapy Studio** based on my own decision and acknowledgement of the inherent risks associated with any physical exercise including yoga. I understand that the classes are gentle and that the instructor will individualize the teaching as much as possible. I agree to be responsible for my own safety and well-being and that I, my heirs, executors, and administrators will hold no one (including Leila Stuart) responsible for any injury, loss or damage, whether physical or mental, arising out of attendance of these yoga classes.*

Date: _______________ **Location** ___________________________ **Signature:** ______________________