Pregnancy Yoga Private classes Registration Form

PERSONAL INFORMATION (PLEASE WRITE CLEARLY)

Name............................................. Date of Birth....................................

Address............................................................................................................

Occupation........................................Due Date and planned place of birth.......................................

Doctor/midwife practice...................................................................... Phone...................................

HEALTH QUESTIONNAIRE

During pregnancy have you experienced any of the following (please circle any which apply to you)

Aching joints Constipation High blood-pressure Pain from fibroids Anaemia

Depression Pre-Eclampsia Low blood-pressure Lower back pain Anxiety

Diabetes Sciatica Sleep disturbances Morning Sickness Asthma

Dizziness Bleeding Breathlessness Headaches Nosebleeds

Heartburn Oedema Pelvic Girdle Pain Varicose veins Other.......................

Please give details.....................................................................................................................................

Previous pregnancies?.......... Previous miscarriages?....... Previous Births?....... Age(s)......................

Please state any injury or had surgery (e.g. caesarean section, knee surgery) that may affect yoga practice.....................................................................................................................................................

Do you smoke? Y/N Do you drink? Y/N Current medication details.........................................

Have you received any treatments from complementary/ alternative practitioners? Y/N

If so, please give details............................................................................................................................

What do you hope to gain from yoga?.................................... How did you hear about me?...............

CLASS AND PAYMENT DETAILS

Venue:

Day/ Time:

Cost:

I will pay via Paypal, please send invoice I will pay cash

I agree, for my own safety and wellbeing, to inform the teacher at the beginning of any class, should any changes in the above information occur, or if any medical, physical or emotional problems arise at any time. If you feel unwell always consult your doctor or midwife.

Signed...................................... Printed......................................... Date.........................