

Therapeutic Yoga Registration Form

Date of Registration _____

Name _____

Address _____
Street City State Zip

Phone _____ **Mobile** _____

Email _____

Emergency Contact _____
Name and Phone

Please describe your past yoga experience and present practice, if any

Health Information

Are you currently experiencing pain or other symptoms such as lack of sleep, inability to perform tasks etc due to the pain?

Briefly rate and describe your pain or other symptoms?

Are you currently on any medication? If so, please indicate for what condition and duration? Please describe any known side effects of these medications (such as change in heart rate, nervousness, lack of coordination, etc.) that may impact your practice.