

# YOGA REGISTRATION/HEALTH HISTORY

All information is confidential and will not be sold to solicitors.

PLEASE TAKE A MOMENT TO COMPLETELY FILL OUT THIS FORM. -thank you Synergize, Inc.

(PLEASE PRINT LEGIBLY!)

## CONTACT INFO

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

May we send you notices about events, specials, etc.? Yes No

Home (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

E-mail address \_\_\_\_\_ (very important!)

May we send you e-mail notices about events, specials, etc.? Yes No

## OTHER INFO

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

How did you find out about us? (Circle all that apply)

Drive-by \_\_\_\_\_ Friend/Family (name please) \_\_\_\_\_ Internet \_\_\_\_\_ Flyer/Where? \_\_\_\_\_

## EMERGENCY CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

## HEALTH HISTORY INFO

Please read each item carefully and circle either YES or NO next to each question.

Please be assured that your answers will be treated in strict confidence.

YES NO Have you taken a yoga class before? How long ago? \_\_\_\_\_ What type(s)? \_\_\_\_\_  
With whom/Studio? \_\_\_\_\_

YES NO Do you smoke? If yes, number of years smoking \_\_\_\_\_

YES NO Are you pregnant? How many weeks? \_\_\_\_\_ What, if any, concerns have you experienced  
during this pregnancy or past pregnancies? \_\_\_\_\_

YES NO Do you currently experience a sedentary or physically inactive lifestyle?

YES NO Do you stretch &/or exercise regularly? If How often? \_\_\_\_\_ What type(s)? \_\_\_\_\_

YES NO Do you have Stress in your life?  
What causes you undue Stress? \_\_\_\_\_  
Where in your body do you hold tension? \_\_\_\_\_  
How do you successfully manage Stress? \_\_\_\_\_

YES NO Do you suffer from anxiety attacks, panic attacks, depression? (Circle all that apply)  
Please explain if known what causes these attacks: \_\_\_\_\_

YES NO During class the instructor may come around to adjust you into a more comfortable or proper position.  
Is it okay for us, as instructors, to adjust you?

**YES NO** Do you have a heart condition? Do you have high blood pressure or low blood pressure? (please circle)  
If YES are you on medications for the above? \_\_\_\_\_

**YES NO** Do you often feel faint or have spells of severe dizziness? Please explain: \_\_\_\_\_

**YES NO** Has your doctor ever told you that you have a bone, joint, or muscular problems, that has been aggravated by exercise or might be made worse with exercise? IF YES Please Explain \_\_\_\_\_

**YES NO** Do you have any of the major muscle or joint injuries or conditions listed below? Please check any condition that applies to you: (If YES please explain in space provided) \_\_\_\_\_

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Bulging or herniated disc | <input type="checkbox"/> Degenerative disc disease | <input type="checkbox"/> Arthritis    |
| <input type="checkbox"/> Fused vertebrae           | <input type="checkbox"/> Multiple Sclerosis        | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Scoliosis                 | <input type="checkbox"/> Neck injury               | <input type="checkbox"/> Hip injury   |
| <input type="checkbox"/> Back Injury               | <input type="checkbox"/> Shoulder injury           | <input type="checkbox"/> Knee injury  |
| <input type="checkbox"/> Carpal Tunnel syndrome    | <input type="checkbox"/> Foot Injury               | <input type="checkbox"/> Other _____  |

**YES NO** Are you on any MEDICATIONS for any of the above? If YES What type and for what? \_\_\_\_\_

**YES NO** Do you have any of the conditions listed below? Please check any condition that apply to you (If YES please explain in space provided): \_\_\_\_\_

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Digestive Conditions | <input type="checkbox"/> Eating disorder             | <input type="checkbox"/> Emphysema                 |
| <input type="checkbox"/> Fibromyalgia         | <input type="checkbox"/> Diabetes or Low blood sugar | <input type="checkbox"/> Hernia                    |
| <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Neurological Conditions     | <input type="checkbox"/> Asthma                    |
| <input type="checkbox"/> Menopause            | <input type="checkbox"/> Chronic Fatigue Syndrome    | <input type="checkbox"/> Lung/Breathing conditions |
| <input type="checkbox"/> Other _____          |  |  |

**YES NO** Are you on any MEDICATIONS for any of the above? If YES What type and for what? \_\_\_\_\_

**YES NO** Any other illnesses or health concerns not listed above? If YES what? \_\_\_\_\_

**YES NO** Do you have any recent or chronic injuries not listed above? If YES, please describe \_\_\_\_\_

**YES NO** Are you under a doctor's care for them? If yes, have you been okayed do exercise? \_\_\_\_\_

**YES NO** If YES are you on medications for the above? \_\_\_\_\_

**YES NO** Have you had surgery in the last three months? Date ( / / ) If YES, Please explain \_\_\_\_\_

With my signature, I, \_\_\_\_\_, understand that yoga is a physical exercise that is sometimes challenging and strenuous. I will personally take each pose to my own level for safety. I hereby affirm that I do not suffer from any disabilities that were not listed above that would prevent or limit my participation in the Synergize, Inc. classes.

**Release of Liability:** In signing below I agree that Synergize, Inc. is in no way responsible for the safekeeping of my personal belongings while I attend class. I understand that classes at Synergize, Inc. may be physically strenuous and I voluntarily participate in them with full knowledge that there is risk of personal injury, property loss or death. I agree that neither I, my heirs, assigns or legal representatives will sue or make any other claims of any kind whatsoever against Synergize, Inc. or its members for any personal injury, property damage/loss, or wrongful death, whether caused by negligence or otherwise.

It is my responsibility to discuss exercise and health concerns with my care providers. I understand that it is solely my responsibility to disclose any existing health conditions. This information will be kept confidential by the instructor and is used solely to make modifications in class.

**I understand fully all of the information above**

**Name (Printed)** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Name (Signature)** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Signature (Parent or Guardian if under 18)** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_