

Wavelengths Yoga health form and waiver

Name: _____ Date: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Business Phone: _____

Email: _____ Age: _____ D.O.B (D/M/Y): _____ Sex: M / F

Emergency Contact (Name & Phone #): _____

How did you hear about us? _____

Are you presently under the care of a medical doctor or health practitioner? _____

Are you on any form of medication? _____ List: _____

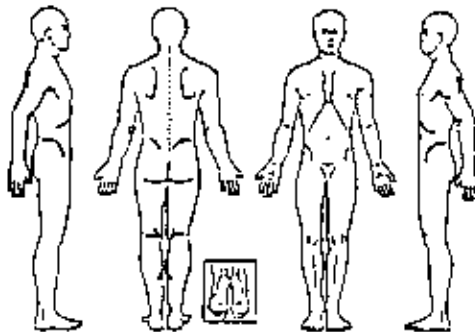
Do you have any restrictions in movement? (please describe) _____

Describe your usual physical activity. _____

Please indicate any of the following that apply to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Fractures | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Allergies/sinus | <input type="checkbox"/> Headaches | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pregnancy- Due date: _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Recent surgery |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hernia | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Osteo Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Clicking/Popping Ears/Jaw | <input type="checkbox"/> Joint problems | <input type="checkbox"/> Hypo/hyper thyroid |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Frozen Shoulder | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Other (list below) |
| <input type="checkbox"/> Dislocation | <input type="checkbox"/> Open wounds/cuts | _____ |

Musculoskeletal – Please indicate any areas of pain by circling them on the diagram below.



Consent for Yoga

It is understood that the Yoga is for relaxation and that it is not meant to diagnose or treat any illness, disease, or any other physical or mental disorder, injury, or condition. I have informed my instructor about my state of health and I have transmitted any recommendations and restrictions on the part of my medical doctor or therapist insofar as yoga is concerned.

Signature _____ Date: _____