ABC YOGA CLUB
YOGA STUDENT INTAKE AND WAIVER FORM

FIRST:_____ MIDDLE:_____ LAST:_____

BIRTHDATE:_____/_____/_____ AGE:_____ _____ FEMALE _____ MALE

STREET:_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ CELL PHONE:_____

EMAIL:_____

EMERGENCY CONTACT:_____ PHONE:_____

HEIGHT:_____FT._____IN. WEIGHT:_____ LBS.

_____ SINGLE _____ MARRIED: ANNIVERSARY DATE:_____/_____/_____ _____ OTHER

HOW DID YOU HEAR ABOUT US?_____

_____ EMPLOYED OCCUPATION:_____

HOBBIES:_____
_____ FULL TIME STUDENT _____ PART TIME STUDENT
___SMOKE EVERY DAY ___SMOKE SOME DAYS ___FORMER SMOKER ___NEVER SMOKED
HOW WOULD YOU RATE YOUR OVERALL HEALTH?
___EXCELLENT ___VERY GOOD ___GOOD ___FAIR ___POOR
WHAT TYPE OF EXERCISE DO YOU DO?
___STRENUOUS ___MODERATE ___LIGHT ___OTHER:_____
HAVE YOU HAD PREVIOUS YOGA EXPERIENCE? ____YES ____NO
IF YES, RESULTS: _____EXCELLENT ____GOOD ____FAIR ____POOR
INDICATE IF YOU HAVE ANY IMMEDIATE FAMILY MEMBERS WITH THE FOLLOWING:
___RHEUMATOID ARTHRITIS ___DIABETES ___LUPUS
___HEART PROBLEM ___CANCER ___ALS ___OTHER:_____
HAVE YOU EVER BEEN HOSPITALIZED? ____YES ____NO
IF YES, WHY AND WHEN: _____

_____
LIST ALL SURGICAL PROCEDURES YOU HAVE HAD AND WHEN THEY OCCURED:
_____

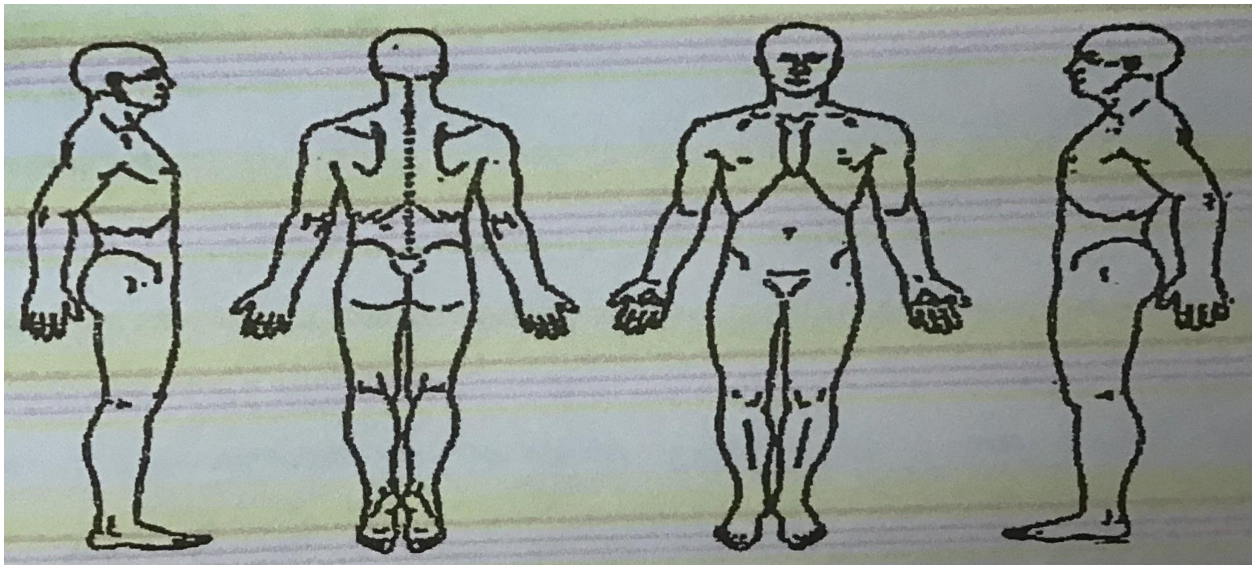
_____
HAVE YOU HAD SIGNIFICANT PAST TRAUMA (FRACTURES, FALLS, AUTO ACCIDENTS, ETC.)?
____YES ____NO IF YES, PLEASE EXPLAIN:

_____

_____
ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITIONS ?
____YES ____NO IF YES, PLEASE LIST NAME AND FACILITY::

_____

INDICATE ON THE DRAWINGS BELOW WHERE YOU HAVE PAIN/SYMPTOMS.



LIST ALL PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING AND FOR WHAT CONDITION: (IF TOO NUMEROUS, ATTACH A COPY OF YOUR MEDICATIONS.)

_____

_____

LIST ALL THE OVER-THE-COUNTER MEDICATIONS, SUPPLEMENTS, AND/OR HERBS YOU ARE CURRENTLY TAKING AND WHY:

_____

_____

WHAT ARE YOUR WELLNESS GOALS?

_____

_____

_____

HAVE YOU LOST THE ABILITY TO DO SOMETHING YOU WOULD LIKE TO REGAIN?
____YES ____NO IF YES, PLEASE LIST:

_____

_____

WHAT CHALLENGES DO YOU HAVE OR WANT TO OVERCOME?

_____

_____

HERE IS A LIST OF THINGS YOGA CAN HELP WITH. PLEASE CIRCLE THE ONES THAT APPLY TO YOU:

STRESS RELIEF PAIN RELIEF BETTER BREATHING FLEXIBILITY
INCREASED STRENGTH WEIGHT MANAGEMENT IMPROVED CIRCULATION
CARDIOVASCULAR CONDITIONING BETTER BODY ALIGNMENT
FOCUS ON THE PRESENT

FOR EACH OF THE CONDITIONS LISTED BELOW, PLACE A CHECK IN THE “PAST” COLUMN IF YOU HAVE HAD THE CONDITION IN THE PAST. IF YOU PRESENTLY HAVE A CONDITION LISTED BELOW, PLACE A CHECK IN THE “NOW” COLUMN.

	YES PAST	NOW	NO
Pregnancy	___	___	___
Headaches	___	___	___
Neck Pain	___	___	___
Whiplash	___	___	___
Upper Back Pain	___	___	___
Mid Back Pain	___	___	___
Low Back Pain	___	___	___
Herniated Disc	___	___	___
Shoulder Pain	___	___	___
Elbow/Upper Arm Pain	___	___	___
Wrist Pain	___	___	___
Hand Pain	___	___	___
Hip Pain	___	___	___
Upper Leg pain	___	___	___
Knee Pain	___	___	___
Ankle/Foot Pain	___	___	___
Jaw Pain	___	___	___
Whiplash	___	___	___
Joint Pain/Stiffness	___	___	___
Arthritis	___	___	___
ALS	___	___	___
Parkinson’s	___	___	___
Multiple Sclerosis	___	___	___
Neuritis/Neuralgia	___	___	___
Fibrositis	___	___	___
Rheumatoid Arthritis	___	___	___
Cancer	___	___	___
Auto Immune Disease	___	___	___
Osteoporosis	___	___	___
Orthopedic Pins/Plates	___	___	___
Tumor, Cysts, Lipomas	___	___	___
Asthma/Breathing Problems	___	___	___
Pneumonia	___	___	___
Chronic Sinusitis	___	___	___
Heart Problems	___	___	___
High Blood Pressure	___	___	___
Low Blood Pressure	___	___	___
Heart Attack	___	___	___
Chest Pains	___	___	___
Stroke	___	___	___
Peripheral Artery Disease	___	___	___
Blood Clots, Phleboliths	___	___	___
Hemophilia	___	___	___
Varicose/Spider Veins	___	___	___
Bad Circulation	___	___	___
Gout	___	___	___
Pregnant	___	___	___

	YES PAST	NOW	NO
Anemia	___	___	___
Raynaud’s	___	___	___
Easy Bruising	___	___	___
Angina	___	___	___
Kidney Stones	___	___	___
Kidney Disorders	___	___	___
Bladder Infection	___	___	___
Painful Urination	___	___	___
Loss of Bladder	___	___	___
Frequent Urination	___	___	___
Abdominal Pain	___	___	___
Irritable Bowel Syndrome	___	___	___
Abdnormal Weight Gain	___	___	___
Abdnormal Weight Loss	___	___	___
Loss of Appetite	___	___	___
Crohn’s	___	___	___
Hernia	___	___	___
Ulcer	___	___	___
Hepatitis	___	___	___
Liver/Gall Bladder Disorder	___	___	___
General Fatigue	___	___	___
High Stress/Anxiety	___	___	___
Panic Attacks	___	___	___
Fibromyalgia	___	___	___
Hypothyroidism	___	___	___
Hyperthyroidism	___	___	___
Endocrine Disorders	___	___	___
Muscular Incoordination	___	___	___
Visual Disturbances	___	___	___
Dizziness	___	___	___
Diabetes	___	___	___
Excessive Thirst	___	___	___
Poor Sleep / Insomnia	___	___	___
Tinnitis, Ear Ringing	___	___	___
Prostte Problems	___	___	___
Smoking / Tobacco Use	___	___	___
Drug / Alcohol Dependence	___	___	___
Allergies	___	___	___
Depression	___	___	___
Grieving	___	___	___
Systemic Lupus	___	___	___
Epilepsy	___	___	___
Dermatitis/Eczema/Rash	___	___	___
HIV/AIDS	___	___	___
Rash	___	___	___
Osteoarthritis	___	___	___
Other Conditions:	___	___	___

ARE THERE CERTAIN MOTIONS OR POSTURES YOU NEED TO AVOID OR THAT ARE PAINFUL OR UNCOMFORTABLE? ____YES ____NO
IF YES, PLEASE LIST AND EXPLAIN:

_____

_____

IF YOU HAVE PAIN(S), HOW OFTEN DO YOU EXPERIENCE YOUR PAIN SYMPTOMS?
___CONSTANTLY (76-100% OF THE TIME) ___FREQUENTLY (51-75% OF THE TIME)
___OCCASIONALLY (26-50% OF THE TIME) ___INTERMITTENTLY (1-25% OF THE TIME)

HOW WOULD YOU DESCRIBE THE TYPE OF PAIN?
___SHOOTING ___NUMB ___DULL ___TINGLY
___SHARP WITH MOTION ___ACHY ___STIFF ___DIFFUSE
___STABBIN WITH MOTION ___SHARP ___BURNING ___STIFF
___SHOOTING WITH MOTION ___ELECTRIC LIKE WITH MOTION
___OTHER:_____

HOW ARE YOUR SYMPTOMS CHANGING WITH TIME?
___GETTING WORSE ___STAYING THE SAME ___GETTING BETTER

USING A SALE FROM 1-10 (10 BEING THE WORST), HOW WOULD YOU RATE YOUR PROBLEM? (PLEASE CIRCLE.)
0 1 2 3 4 5 6 7 8 9 10

HOW MUCH HAS THE PROBLEM INTERFERED WITH YOUR WORK?
__NOT AT ALL ___A LITTLE BIT ___MODERATELY ___QUITE A BIT __EXTREMELY

HOW MUCH HAS THE PROBLEM INTERFERED WITH YOUR SOCIAL ACTIVITIES?
__NOT AT ALL ___A LITTLE BIT ___MODERATELY ___QUITE A BIT __EXTREMELY

WHO ELSE HAVE YOU SEEN FOR YOUR PROBLEM?
___CHIROPRACTOR ___NEUROLOGIST ___PRIMARY CARE PHYSICIAN
___ER PHYSICIAN ___ORTHOPEDIST ___MASSAGE THERAPIST
___PHYSICAL THERAPIST ___NO ONE ___OTHER:_____

RECENT: ___X-RAYS ___MRI ___CT ___LAB WORK TAKEN:_____

HOW LONG HAVE YOU HAD THIS PROBLEM?_____

HOW DO YOU THINK YOUR PROBLEM BEGAN?_____

DO YOU CONSIDER THIS PROBLEM TO BE SEVERE? __YES __YES, AT TIMES __NO

WHAT AGGRAVATES YOUR PROBLEM?_____

WHAT HELPS YOUR PROBLEM?_____

WHAT CONCERNS YOU THE MOST ABOUT YOUR PROBLEM; WHAT DOES IT PREVENT YOU FROM DOING?_____

_____

ANYTHING ELSE PERTINENT TO YOGA? _____

I, _____ (PRINT STUDENT'S FIRST AND LAST NAME) UNDERSTAND THAT YOGA INCLUDES PHYSICAL MOVEMENTS AS WELL AS AN OPPORTUNITY FOR RELAXATION, STRESS RE-EDUCATION AND RELIEF OF MUSCULAR TENSION. AS IN THE CASE WITH ANY PHYSICAL ACTIVITY, THE RISK OF INJURY, EVEN SERIOUS OR DISABLING, IS ALWAYS PRESENT AND CANNOT BE ENTIRELY ELIMINATED. IF I EXPERIENCE ANY PAIN OR DISCOMFORT, I WILL LISTEN TO MY BODY, ADJUST THE POSTURE AND ASK FOR SUPPORT FROM THE TEACHER. I WILL CONTINUE TO BREATHE SMOOTHLY.

YOGA IS NOT A SUBSTITUTE FOR MEDICAL ATTENTION, EXAMINATION, DIAGNOSIS OR TREATMENT. YOGA IS NOT RECOMMENDED AND IS NOT SAFE UNDER CERTAIN MEDICAL CONDITIONS. I AFFIRM THAT I ALONE AM RESPONSIBLE TO DECIDE WHETHER TO PRACTICE YOGA.

I HEREBY AGREE THAT I WILL BE 100% RESPONSIBLE FOR ANY COST INCURRED FOR MEDICAL ATTENTION AS A RESULT OF MY PARTICIPATION IN YOGA CLASS, TAKING FULL RESPONSIBILITY FOR OVER EXERTION, ACCIDENTS AND ALL INCIDENTS AND RELEASE ABC YOGA CLUB, OWNER, DIRECTOR, AND INSTRUCTOR(S) AS OF THIS DATE AS SIGNED BELOW.

_____ _____
SIGNATURE OF STUDENT DATE

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE