17 PURDY AVENUE

RYE, NY 10580

YOGA & YOGA THERAPY REGISTRATION & HEALTH QUESTIONNAIRE

First Name..... Last Name .....

Address.....

City..... State..... Zip.....

Phone: Home ( )..... Work ( ).....

Cell ( )..... Email: .....

Date of Birth ...../...../..... Occupation: .....

Emergency Contact..... Phone ( ).....

Have you done Yoga before? Y/ N If yes, what type(s) and for how long?

.....

Referral Source: .....

What do you hope to gain from **yoga** and/ or yoga therapy? .....
.....

Please describe your present state of physical and emotional **health**: .....

.....

.....

Rate the amount of stress in your life: ____High____Meduim____Low

Please describe sources of stress: .....

PLEASE TURN OVER

Please circle any of the following conditions that apply to you:

Arthritis	Back pain	Neck pain
Knee problems	Joint replacements (specify)	Allergies
Recent fractures	Recent surgery (specify)	Ulcers
Hypoglycemia	Diabetes	Migraines/ frequent headaches
Cancer	Epilepsy/ siezues	Infectious Disease
Depression	Anxiety	Panic Attacks
High blood pressure	Low blood pressure	Chest Pain
Dizzy spells/ Fainting	Heart disease	Other body pain (specify)

Detached Retina/ Glaucoma/ other eye problems

Other Chronic Illness/ condition (specify) ……..

Please list all current medications: ……

Please describe any conditions you may have which affect your mobility or are likely to cause you concern when doing Yoga? …….

…….....

Please describe any other conditions or health issues you believe would be helpful for me to be aware of::……

Are you pregnant? Y/N If yes, Due Date:____/____/____

Physician's Name: .....

Phone: .....

Address:.....

I take full responsibility for my health during yoga and/ or yoga therapy, including any injuries. I will inform Lauren Rose, LCSW, RYT of any changes in my medical and/or emotional condition.

Signature ..... Date .....