

YOGA REGISTRATION FORM

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|--|--------|-------|
| Name | DOB | |
| Address | P/Code | |
| Phone | Mobile | Email |
| How did you find out about my Yoga classes | | |

The following information will assist me in class preparation.
All information provided is strictly confidential

Medical History
Do you, or have you ever had, any of the following? (circle those which apply)

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|---------------------|----------|----------------------|---------------|
| Asthma | Diabetes | Arthritis | Heart Disease |
| High Blood Pressure | Epilepsy | Neck/Back pain/stiff | Dizziness |

Have you had any surgery or trauma in the last 6 months (broken bones, falls, accidents, etc.)? **NO YES** what and when?

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Have you ever done Yoga before. **NO YES** If yes when and what style and for how long?

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Is there anything else you think would be important or relevant for me to know?

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Would you like to be included on my mailing list?
YES NO

If **YES** would you prefer? **Email Normal Mail** (circle your preference)

Thank you
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