

Registration Form

Please complete this form as best you can so that I may have the background knowledge I need to make your yoga practice fit your needs. All information is confidential and will not be shared with anyone else.

Please **PRINT** clearly.

Full name _____ Date _____

Address _____

Phone number(s) _____ Email _____

Class title _____ Day(s) & time of class _____

How did you hear about AJYOGA? _____

Please circle any areas of concern regarding your health.

- | | | | |
|--------------------|---------------------|--------------|------------|
| Anxiety | Headaches | Tendonitis | Legs |
| Asthma | High blood pressure | Ankles | Lower back |
| Carpal tunnel | Hypoglycemia | Elbows | Neck |
| Chronic illness | Low blood pressure | Eyes | Sciatica |
| Chronic/acute pain | Menopausal problems | Feet | Scoliosis |
| Depression | Menstrual problems | Hands/wrists | Shoulders |
| Diabetes | Pregnancy | Heart | Upper back |
| Dizziness | Sleeping Disorder | Hips | Stress |
| Digestive problems | Surgery | Knees | |

Please list any other mental or physical health concerns that might affect your practice. Please be specific.

Are you currently being treated, or have you in the past been treated, for any of the above concerns? If so, list when and by whom.

Do you have prior yoga experience? If yes, what style, and how long?

Do you meditate?

_____ No. _____ No, but I'd like to try it. _____ Yes, not regularly. _____ Yes, regularly.

Do you have a regular exercise program? Please explain (how often, what type of exercise)

What do you hope to get out of your yoga sessions? Do you have any specific goals – mental, physical or spiritual?
