



## Registration Form

Please complete this form and bring it with you to your first session.

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Date: \_\_\_\_\_ Teacher's Name: \_\_\_\_\_

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Name: \_\_\_\_\_

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Address: \_\_\_\_\_

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Email: \_\_\_\_\_

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Phone (day): \_\_\_\_\_ Phone (evening): \_\_\_\_\_

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Occupation: \_\_\_\_\_

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1. Have you practiced yoga before?.....

2. For how long?.....

3. Where?.....

4. Do you have any of the following (please circle):

Low blood pressure	Depression	Arthritis	High blood pressure
Headaches	Diabetes	Insomnia	Menstrual Problems

5. Are you pregnant (how many weeks)?.....

6. Are you on any medication?.....

7. Have you had any major injuries / accidents?.....

8. Do you have any other health issues that will affect your yoga practice?

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9. Would you like to be included on our mailing list?..... YES/NO

10. Where did you hear about us (please circle):

Yellow Pages	Friends	Flyer (where)	Advertisement (where)
Our Sign	Our Website	Another Website	Other (please specify)

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