

Registration form for Baby Yoga Classes

Please note that all information given on this form will be treated as strictly confidential. The information given allows me to plan sessions in order to meet the needs of mothers and their babies and to ensure that the sessions are suitable and appropriate for those wishing to attend.

Please fill all sections

Name of mother:		Name of baby:	
Address:		Baby boy: <input type="checkbox"/>	Or Baby girl: <input type="checkbox"/>
		Baby's date of birth:	
Telephone:		Previous births?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Email:		Ages of older children:	
BIRTH EXPERIENCES FOR THIS BABY			
Length of labour:	Was labour self starting? <input type="checkbox"/>	Induced? <input type="checkbox"/>	Accelerated? <input type="checkbox"/>
Nature of delivery:	Ventouse: <input type="checkbox"/>	Forceps: <input type="checkbox"/>	Caesarean: <input type="checkbox"/>
Delivery environment:	Hospital: <input type="checkbox"/> Home: <input type="checkbox"/>	Waterbirth: <input type="checkbox"/>	Other?:
Name of midwifery team providing ante/ postnatal care:			
Any drugs administered during labour?		Pethidine? <input type="checkbox"/> Epidural? <input type="checkbox"/>	Gas and air? <input type="checkbox"/> Other?.....
Any damage to the perineum suffered? <input type="checkbox"/>		Any stitches following tearing/episiotomy? <input type="checkbox"/>	
Any post partum haemorrhage? Yes/No	Was your baby full term? <input type="checkbox"/>	Premature? <input type="checkbox"/>	'Overdue'? <input type="checkbox"/>
At what stage was the umbilical cord cut?			
State of health of baby at and immediately after birth:			
MOTHER POSTNATALLY			
Since the birth of the baby, have you experienced any of the following? Please tick those conditions which have affected you.			
Sacro-iliac pain <input type="checkbox"/>	Back pain <input type="checkbox"/>	Stiff neck/shoulders <input type="checkbox"/>	Joint pain <input type="checkbox"/>
Sciatica <input type="checkbox"/>	High blood pressure <input type="checkbox"/>	Piles <input type="checkbox"/>	Anaemia <input type="checkbox"/>
Prolonged bleeding <input type="checkbox"/>	Mastitis <input type="checkbox"/>	Depression <input type="checkbox"/>	Anxiety <input type="checkbox"/>
Exhaustion <input type="checkbox"/>			
Please give details of any of the above which you have ticked if you need to:			
BABY POSTNATALLY			
Since birth has your baby experienced any of the following?			
Colic	Jaundice	Irritability	Hip dislocation
Cranial compression			
Please give details of any of the above which you have ticked if you need to:			
Have you studied yoga before? Please give details of how long and what style of yoga			
Prior to this birth, have you suffered any injury or undergone any surgery that may have some bearing on your yoga practice? If so please state details			
Do you have a medical condition that may affect your yoga practice? If so please state details			
Why have you chosen to come to this class and what do you hope to gain from it?			
Please print this form and post the completed form to: Sofya Ansari 16 Prospect Drive, Cardiff CF5 2HN			

Thank you for completing this form