

Registration form for Yoga Classes

Please note that all information given on this form will be treated as strictly confidential.

Name		Date of birth	
Address:			
Telephone:			
Email:			
Since having children, 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:			
Have you studied yoga before? Please give details of how long and what style of yoga			
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			
Please note that if you have answered yes to the last three questions, it is advised that you let your doctor know of your yoga practice and check with your doctor whether it is suitable for you			
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