HEALTH INFORMATION

NAME____ DATE: ________________________

DOB: ___________________________ GENDER: FEMALE _____________ MALE ____________

PRIMARY REASON FOR INTEREST IN CLASS? ____

HOW DID YOU HEAR ABOUT OUR PROGRAM? ____

DO YOU HAVE ANY AREAS OF PAIN, TENSION OR PROBLEMS? ____

WHAT IS YOUR OCCUPATION? ____

DO YOU EXERCISE REGULARLY? YES ______ NO ______ TYPE OF EXERCISE _________________________________

ARE YOU UNDER A DOCTOR, CHIROPRACTOR OR OTHER HEALTH PRACTITIONER'S CARE? YES ______ NO ______

IF YES, PLEASE DESCRIBE: ____

DRS. NAME: __________________________________ ARE YOU TAKING MEDICATIONS? YES ________ NO ________

IF YES, PLEASE LIST: ____

HAVE YOU BEEN IN AN ACCIDENT OR SUFFERED INJURIES IN THE PAST TWO YEARS? YES ________ NO ________

ARE YOU PREGNANT OR NURSING? YES ________ HOW MANY WEEKS? ________ , NO________

ANY CURRENT PAIN COMPLAINTS? YES _______ NO _______ IF YES PLEASE DESCRIBE: ________________________

____

Please check if you have any of the following:

FOOD ALLERGIES ______LIST:____

ALLERIGES	______	ARTHRITIS	______	ATHELTES FOOT	______
BLOOD CLOTS	______	CARPAL TUNNEL	______	CIRCULATORY PROBLEMS	______
DIABETES	______	HEART DISEASE	______	HIGH BLOOD PRESSURE	______
JOINT PROBLEMS	______	LOW BLOOD PRESSURE	______	MUSCULAR INJURIES	______
RESPIRATORY PROBLEMS	______	SKELETAL INJURIES	______	SKIN PROBLEMS	______
SPINAL PROBLEMS	______	VARICOSE VEINS	______	ABDOMINAL PROBLEMS	______
CHEST PAIN	______	CONSTIPATION	______	DIGESTIVE PROBLEMS	______
DIZZINESS	______	DEPRESSION	______	FATIGUE	______
INSOMNIA	______	MIGRANE HEADACHES	______	SINUSITIS	______
JAW PAIN/TMJ	______	WARTS	______	BRUISE EASILY	______
EPILEPSY OR SEIZURES	______	NUMBNESS	______	STABBING PAIN	______
OSTEOPOROSIS	______				

PLEASE DESCRIBE ANY CONDITION YOU CHECKED ABOVE OR THAT WOULD PRECLUDE YOU FROM PERFORMING THE EXERCISES:____

- I understand that the Instructor does not diagnose illness, disease, or any physical disorder.
- The Instructor does not prescribe treatment or medications or perform spinal manipulation.
- This class is not a substitute for medical examination or diagnosis.
- I have, to the best of my knowledge, stated all of my known medical conditions. I take it upon myself to keep the instructor updated on my physical health. I understand that any illicit or sexually suggestive remarks/advances made by me will result in immediate termination of the session. I will be liable for payment of the scheduled appointment.

CLIENT SIGNATURE ____ DATE _____________________

PRACTITIONER SIGNATURE ____ DATE _____________________

*Consent to treatment of a minor: By my signature, I hereby authorize the instructor to administer Yoga to my child or dependent as they deem necessary.

Signature of Parent or Guardian ____ Date ______________________

CONTACT INFORMATION:

NAME: ____

HOME ADDRESS: ____

____

____

HOME PHONE NUMBER: ____

EMAIL ADDRESS: ____

OUR PRIMARY SOURCE OF COMMUNICATION FOR CANCELLED CLASSES OR CHANGES TO THE CLASS SCHEDULE WILL BE THROUGH EMAIL. PLEASE LIST YOUR EMAIL ADDRESS ABOVE TO BE NOTIFIED OF THESE IMPORTANT ANNOUNCEMENTS.

EMERGENCY CONTACTS:

IN CASE OF EMERGENCY PLEASE CALL:

1) NAME: ______________________________ RELATION: ______________________

PHONE: ______________________________

2) NAME: ______________________________ RELATION: ______________________

PHONE: ______________________________

I, ______________________________ give my permission to the staff at Creative
Please print Name
Therapeutics to contact the above mentioned people if a situation arises during my participation in the class that deems this contact appropriate.

______________________________ ______________
PLEASE SIGN DATE