SUN SALUTATIONS YOGA & WELLNESS CENTER: PERSONAL INFORMATION FORM

(This information will be kept on file with complete confidentiality.)

Name: ____________________ **Nickname:** ____________ **M or F**

DOB: ________ **Home Phone #:** ____________ **Cell #:** ____________

Mailing Address: ____________________

E-mail Address: ____________________

Local Emergency Contacts
(in the unlikely event that there is an emergency, who should we call?):

1.) Name: ____________ **Phone #:** ____________

Relationship to person/s: ____________

2.) Name: ____________ **Phone #:** ____________

Relationship to person/s: ____________

3.) Name: ____________ **Phone #:** ____________

Relationship to person/s: ____________

Your Doctor's Name: ____________________

Address: ____________ **Doctor Phone #:** ____________

Please list and describe any medical conditions you previously and currently have (including high/low blood pressure, surgeries (including on the eyes), asthma, pregnancy, heart conditions, physical injuries, scoliosis, osteoporosis, sciatica, anxiety, insomnia, carpal tunnel syndrome, etc.):

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____

Do you have any allergies? If so, to what: ____________________

____

Are you on any medications? If so, what are they: ____________________

____

Have you ever taken a yoga class before? Please describe: ____________________

____

What would you like to get from your yoga class? ____________________

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Additional Comments: ____________________

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____

Student or Parent/Guardian Signature: ____________________ **Date:** ____________