P: 0407 206 010 Ella @ FIELDS OF YOGA

Mansfield Victoria, 3722

W: www.fieldsofyoga.com.au

FB: FIELDS of YOGA Mansfield

NEW STUDENT CONFIDENTIAL FORM

NAME:_____

DATE OF BIRTH: _____

POSTAL ADDRESS:_____

TOWN/SUBURB:_____**STATE:**_____**P/CODE**_____

PHONE:_____**Email:**_____

- **This information is used to inform you of any timetable changes, news and events and will not be forwarded to any third parties**

EMERGENCY CONTACT NAME & NUMBER:_____

How did you hear about FIELDS OF YOGA?_____

Have you practiced YOGA before YES/NO_____

- **If yes, please provide details of the type of class and how long/often you practiced?**

  _____

  _____

  _____

- **What brought you to YOGA? Postures/Meditation/ Chanting/time to you**

  _____

  _____

AGREEMENT: I am participating in yoga classes and workshops offered by Fields of Yoga which I will receive information about Yoga, meditation and health. I recognise that yoga requires physical exertion that may cause physical injury and I am fully aware of the risks involved. I agree to check with my doctor or therapist if I have any difficulties or concerns about taking part in a class. I agree to advise the teacher of any medical conditions I may have and if those conditions change at any time.

I agree to take full responsibility for any risks, injuries or damages, known or unknown, which might incur as a result of participating in a practice. I voluntarily and expressly waiver any claim I may have against Fields of Yoga for injury or damages that I sustain as a result of participating in a YOGA practice.

SIGNATURE: _____ **DATE:**_____

HEALTH QUESTIONS:

Do you have any of the following? If YES, Please provide details:

HIGH BLOOD PRESSURE	**NO/YES**	_____
LOW BLOOD PRESSURE	**NO/YES**	_____
HEART DISEASE	**NO/YES**	_____
ARTHRITIS	**NO/YES**	_____
DIABETES	**NO/YES**	_____
EPILEPSY	**NO/YES**	_____
ASTHMA	**NO/YES**	_____
DEPRESSION	**NO/YES**	_____
IBS	**NO/YES**	_____
THYRIOD ISSUES	**NO/YES**	_____
ADRENAL FATIGUE	**NO/YES**	_____
DO YOU SMOKE?	**NO/YES**	_____
EYE PROBLEMS	**NO/YES**	_____
MENOPAUSE	**NO/YES**	_____
RECENT SURGERY	**NO/YES**	_____
ENDOMETRIOSIS	**NO/YES**	_____
MIGRAINES	**NO/YES**	_____

CURRENT or RECENT PREGNANCY _____

_____

TRIMESTER STAGE_____

ANY OTHER KNOWN CONDITIONS_____

_____

_____

_____

_____

For the below questions, please indicate the location on the diagram provided and advise the teacher on the types of movement that cause pain:

Joint Pain **NO/YES** _____

Muscle Pain **NO/YES** _____

Back Pain **NO/YES** _____

Foot or Heel Pain **NO/YES** _____

Are there any conditions I should be aware of? Please circle on figure below:
NO/YES_____
_____
_____

_____