YOGA CLIENT REGISTRATION & LIABILITY WAIVER

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOW DID YOU FIND US?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Client Contact Information** | | | | | | | | | | | |
| First Name: | | Last Name: | | | | | | DOB: | | | Age: |
| Address: | | | | | | City: | | State: | | Zip: | |
| Phone: | | | | Email: | | | | | | | |
| Occupation: | | | Emergency Contact: | | | | Contact Phone: | | | | |
| **Client History/Background** | | | | | | | | | | | |
| Describe your goals for private yoga sessions. | | | | | | | | | | | |
| Have you practiced yoga before? If yes, what style and for how long? | | | | | | | | | | | |
| List all injuries and surgeries. Provide dates and treatments received. | | | | | | | | | | | |
| Do you have pain or physical limitation? If yes, please describe and circle areas on adjacent body chart. | | | | | **R L L R** | | | | | | |
| What treatment are you receiving, or have you tried, for this pain/limitation. | | | | | | | | | | | |
| What is your relationship to this pain/limitation? What do you tell yourself about this pain/limitation? | | | | | | | | | | | |
| Please list medications and supplements. The number of years taken and their purpose. | | | | | | | | | | | |
| Do you perform any repetitive movement during the day (work or recreation)? If yes, please describe. | | | | | | | | | | | |
| How much and what kind of movement/exercise do you do in an average week? | | | | | | | | | | | |
| Describe your average state of mind (clear, focused, foggy, dull). | | | | | | | | | | | |
| Describe your average stress level. What triggers stress? How do you release/cope with stress? | | | | | | | | | | | |
| Describe your average energy level (extreme fatigue, low, average, high, wired). | | | | | | | | | | | |
| Describe your average breathing pattern (smooth/jagged, audible/quiet, shallow/deep). | | | | | | | | | | | |
| Describe your average body temperature (warm/cold). | | | | | | | | | | | |
| Describe your average eating pattern (i.e. regular/irregular/skip meals, largest meal is). List most common foods eaten as well as any food allergies. Do you have or have you had any chronic eating disorders or food related issues? | | | | | | | | | | | |
| Describe your average state of digestion and elimination (heart burn, constipation, frequent urination, etc…). | | | | | | | | | | | |
| Describe your average sleep pattern (consistent/inconsistent, time go to sleep/awaken, number of hours sleep, fall asleep easily, awaken frequently). | | | | | | | | | | | |
| How many caffeinated beverages and glasses of water do you drink per day? | | | | | | | | | | | |
| Do you smoke tobacco, drink alcohol, use cannabis or other drugs? If so how frequently? Do you have (or have you had) any addiction or substance abuse issues? | | | | | | | | | | | |
| Describe your average weekday and weekend. | | | | | | | | | | | |
| Describe your religious/spiritual life. | | | | | | | | | | | |
| Describe your family/community life. | | | | | | | | | | | |
| Describe how you have fun in your life. | | | | | | | | | | | |
| What gives you a sense of peace/calm. | | | | | | | | | | | |
| **Medical History** (do you have or have you had): | | | | | | | | | | | |
| \_\_High Blood Pressure  \_\_Low Blood Pressure  \_\_Hypoglycemia  \_\_Diabetes  \_\_Anemia  \_\_Rheumatoid Arthritis  \_\_Arthritis  \_\_Glaucoma  \_\_Visual difficulties  \_\_Hearing difficulties  \_\_Dizziness/Vertigo  \_\_Headaches | \_\_Osteoporosis  \_\_Heart problems  \_\_Epilepsy  \_\_Seizures  \_\_ Tightness/Pain in Chest  \_\_Asthma  \_\_Snoring/Sleep Apnea  \_\_Night sweats  \_\_ Chronic Coughing  \_\_Frequent Sighing/Yawning/Sniffing | | | | \_\_Fibromyalgia  \_\_Chronic Fatigue  \_\_Depression  \_\_ Anxiety  \_\_Broken bones  \_\_Unexplained fractures  \_\_Unstable/dislocated joints  \_\_Joint swelling  \_\_Implants/artificial joints  \_\_Hernias or ruptures  \_\_Cancer  \_\_Major surgeries | | | | \_\_Back problems  \_\_Pinched nerves  \_\_Disc issues  \_\_Sciatica  \_\_Motor Vehicle Accidents  \_\_Traumatic accidents  \_\_ Pregnant  \_\_Hysterectomy  \_\_Menstrual challenges  \_\_Menopause challenges  \_\_Other | | |
| Have you experienced other health problems or challenges in your life? | | | | | | | | | | | |
| Is there anything else you would like to share? | | | | | | | | | | | |

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| **Agreement of Release and Waiver of Liability** |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby agree to the following:   1. That I am participating in yoga sessions offered by One to One Yoga and Sonia Weirich during which I will receive information and instruction about yoga, health and wellbeing. I recognize that yoga requires physical exertion, which may be strenuous and may cause physical injury, and I am fully aware of the risks and hazards involved. 2. I understand that it is my responsibility to consult with a physician prior to and regarding my participation in these yoga sessions. I represent and warrant that I am physically fit and have no medical conditions which would prevent my full participation in yoga sessions. 3. In consideration of being permitted to participate in yoga sessions, I agree to assume full responsibility for any risks, injuries or damages, known or unknown, which I might incur as a result of participating in yoga sessions. 4. In further consideration of being permitted to participate in yoga sessions, I knowingly, voluntarily and expressly waive any claim I may have against One to One Yoga or Sonia Weirich for injury or damages that I may sustain as a result of participating in the yoga sessions. 5. I, my heirs or legal representatives forever release, waive, discharge and covenant not to sue One to One Yoga or Sonia Weirich for any injury or death caused by their negligence or other acts.   I have read the above release and waiver of liability and fully understand the contents. I voluntarily agree to the terms and conditions stated above.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature Date |
| **Cancellation and Missed Appointments Policy** |
| We understand there may be extenuating circumstances; however, we request that any cancellation or rescheduling of your appointment be made at least 24 hours in advance of the scheduled visit. Missed appointments or appointments cancelled less than 24 hours in advance can prevent us from serving others in need and disrupt our practitioner’s schedules. **The fee for missed appointments/late cancellation is $50.** I, the undersigned, have been informed about the cancellation and missed appointment policy. I have further been informed that appointment reminders are a courtesy and that I am responsible for remembering my appointment.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature Date |