

# Yoga Sol Registration – Student Information

Please fill out every item neatly and clearly giving thought to your words. Thank You

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Email Address \_\_\_\_\_

New Student Yes No If no, how many years have you studied Iyengar Yoga? \_\_\_\_\_

Occupation \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex M F

Please check areas of concern regarding your health. Write pertinent details below or on the back of this sheet (such as when it started, what your symptoms are, etc.)

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|--|--|---|--|
| <input type="checkbox"/> Allergy                 | <input type="checkbox"/> Dizziness                 | <input type="checkbox"/> Kidney             | <input type="checkbox"/> Pregnancy         |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Eyes                      | <input type="checkbox"/> Knees              | <input type="checkbox"/> Post-partum       |
| <input type="checkbox"/> Ankles/Feet             | <input type="checkbox"/> Gastrointestinal disorder | <input type="checkbox"/> Liver              | <input type="checkbox"/> Prolonged illness |
| <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Headache                  | <input type="checkbox"/> Lower back         | <input type="checkbox"/> Prostate          |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Heart condition           | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Recent Surgery    |
| <input type="checkbox"/> Auto-immune dysfunction | <input type="checkbox"/> Heel spur                 | <input type="checkbox"/> Menopausal         | <input type="checkbox"/> Sedentary         |
| <input type="checkbox"/> Bladder                 | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Sciatica          |
| <input type="checkbox"/> Carpal Tunnel           | <input type="checkbox"/> Hips/Legs                 | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scoliosis         |
| <input type="checkbox"/> Chronic Fatigue         | <input type="checkbox"/> HIV-related               | <input type="checkbox"/> Neck               | <input type="checkbox"/> Shoulders         |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Hypoglycemia              | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Thyroid           |
| <input type="checkbox"/> Depression              | <input type="checkbox"/> Insomnia                  | <input type="checkbox"/> Plantar fasciitis  | <input type="checkbox"/> Wrist/Hand        |

Please describe conditions not listed above or elaborate on those checked \_\_\_\_\_

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List medications, remedies, and supplements used \_\_\_\_\_

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Have you used? (Circle answers): Acupuncture      Chinese Medicine      Chiropractic      Massage

Deep Tissue Therapy      Physical Therapy      Psychotherapy      Homeopathic Medicine

Have you ever been in a car accident or had a traumatic injury? Yes No If yes, what year? \_\_\_\_\_

I am in good general health and feel physically capable and ready to engage in physical yoga movement. I recognize the potential risk inherent in any physical exercise and take responsibility for determining my own level of participation based on my body's responses.

Signature \_\_\_\_\_ Date \_\_\_\_\_

How did you hear about us? Phone Book\_\_ Flyer\_\_ Friend\_\_ Internet\_\_ Newspaper\_\_ Other\_\_\_\_\_