Client History / Information Form

First Name:_____ Last Name: _____

Email Address **Date of Birth**

Address **State** **Zip**

Cell Phone **Home Phone (if different)**

Emergency Contact **Phone**

May we email you reminders, updates, or promotions? Y N

May we text you reminders, updates, or promotions? Y N

If so, who is your cell phone provider? _____

Whom may we thank for your referral? _____

What benefits do you hope to obtain from yoga?

Are you experiencing an unusually stressful situation?

Client History / Information Form

First Name:_____ Last Name: _____

Place an "X" in appropriate boxes to identify all conditions you have experienced

Heart Health		**Spinal Health**	
Heart Disease		Herniated Disc	
High Blood Pressure		Spondylolisthesis / Spondylosis	
Low Blood Pressure		SI Joint Instability	
Joint Health			
Shoulder Injury		Knee Replacement	
Hip Replacement		Knee Injury	
Hip Injury		Carpal Tunnel	
Eye Health			
Glaucoma		Asthma / Breathing Problems	
Detached Retina		Cancer	

Is there anything else about your health we should know?

_____

_____

_____

_____

Signature:_____**Date:**_____