



1. Full Name: \_\_\_\_\_

2. Email Address: \_\_\_\_\_

3. Mobile Number: \_\_\_\_\_

4. Would you like to be on our mailing list?  Yes  No

5. Emergency Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

6. Do you have any of the following? (Please tick)

Back pain  Spinal issues  High blood pressure

Low blood pressure  Hip injury  Knee injury

Shoulder pain  Anxiety  Pregnant \_\_\_\_\_ Weeks

Other (please specify) \_\_\_\_\_

7. If you answered, "yes" to any of the above, please provide details

\_\_\_\_\_  
\_\_\_\_\_

8. Have you practiced yoga before?  Yes  No

If so, what style/s? \_\_\_\_\_

If so, for how long? \_\_\_\_\_

9. How regularly do you practice? \_\_\_\_\_

10. Is there any other information that would assist us in better looking after you? \_\_\_\_\_

\_\_\_\_\_

### Medical Disclaimer

I confirm that any medical condition has been assessed by a licensed Medical practitioner, who has authorised my participation in a physical yoga practice. I provide consent to receive emergency medical treatment in the event of illness or injury. I acknowledge the information provided above is correct, should anything change I understand it is my responsibility to notify Geelong City Yoga prior to commencing my next class, workshop or retreat. I expressly release Geelong City Yoga from and against all actions and claims of personal injury.

11. I have read and understood the medical disclaimer  Yes  No

Signature: \_\_\_\_\_

Date: \_\_\_\_\_