

REGISTRATION FORM
all elements yoga

select one: ____ drop in ____ free class ____ class signup

Name: _____

Address: _____

City/Zip: _____

Phone: _____

E-mail: _____

Birthdate: _____

Occupation: _____

Referred by: _____

Please mark any medical condition(s) past/present:

- | | |
|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Back Condition (specify) _____ |
| <input type="checkbox"/> Arthritis | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Condition (specify) _____ |
| <input type="checkbox"/> Chronic Fatigue | _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mental Condition (specify) _____ |
| <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Neck Condition (specify) _____ |
| <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> Hyper Thyroid | <input type="checkbox"/> Recent Surgery (specify) _____ |
| <input type="checkbox"/> Hypo Thyroid | _____ |
| <input type="checkbox"/> Pregnant; Due ___/___/___ | <input type="checkbox"/> Other: _____ |

Please list current prescription medications: _____

Previous yoga experience and years: _____

Emergency contact name and phone: _____

Please read and sign:

I accept responsibility for my own health and safety. I relinquish All Elements Yoga, LLC and instructors from all liability.

I understand and accept that there will be NO REFUNDS for classes I purchased but did not attend.

Signature

Date