

Center for Pain and Supportive Care

Yoga Intake and Waiver Form

Registrant Information

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Email _____ Phone _____

- Check here if you would like to receive occasional emails/postal mailings detailing schedule changes upcoming/new classes, workshops, demonstrations, and other CPSC alternative health offerings.

Emergency Contact

Name _____ Relationship to Student _____ Phone _____

General Information

How did you hear about us? _____

Have you practiced yoga before? Yes No

If yes, for how long? _____ Which style(s) of yoga? _____

What are your reasons for practicing yoga? Please check all that apply.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Stress reduction | <input type="checkbox"/> Mental clarity | <input type="checkbox"/> Spiritual growth | <input type="checkbox"/> Confidence |
| <input type="checkbox"/> Weight management | <input type="checkbox"/> Flexibility | <input type="checkbox"/> Strength | <input type="checkbox"/> Overall wellbeing |
| <input type="checkbox"/> Manage chronic pain | <input type="checkbox"/> Manage illness | <input type="checkbox"/> Other | |
- Specify: _____ Specify: _____ Specify: _____
-

Medical Information

Please check all that apply

- | | | |
|--|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Anxiety | <input type="checkbox"/> GI Condition |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Heart/Circulatory Condition | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Chronic Headache | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Muscular Injury | <input type="checkbox"/> Neck/Back/Spine Injury |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Bulging/Herniated Disc | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Prolonged illness | <input type="checkbox"/> Recent major surgery | <input type="checkbox"/> Other medical condition, injury or disability |
- Specify: _____ Specify: _____ Specify: _____
-

If you are currently taking medication or have any serious allergies that should be made known to medical personnel in case of an emergency, please indicate them here: _____

Privacy Statement: The entities of Center for Pain and Supportive Care are committed to protecting your privacy and all information provided to us in our registration process. Our participant information is not available to any outside person or organization.

Waiver and Liability Release

- **Anyone under 18 years of age must have this form signed by a parent or guardian.**
- Participant understands that it is his/her responsibility to consult with a physician prior to and regarding participation in yoga as participation involves physical exertion that can be strenuous and may cause injury.
- Participant agrees to inform his/her instructor immediately of any physical or mental condition that could possibly prevent his/her full participation in yoga classes, demonstrations, or workshops.
- Participant hereby freely and expressly assumes any and all risk of injury and agrees to release and hold harmless Center for Pain and Supportive Care, its owners, partners, and employees regarding said injury/injuries.
- Participant accepts full responsibility for any medical expenses incurred due to participation in yoga.
- Participant accepts that neither the instructor nor the hosting facility is liable for damages to or loss of property resulting from participation.
- This release is binding upon Participant, and Participant's heirs, assignees, and legal representatives.

Please sign below to indicate that you have read and agree to the terms specified above.

Participant Signature _____ Date _____

Participant Name (PRINT) _____

Parent/Guardian Signature _____ Date _____
