

## ONE YOGA REGISTRATION FORM

Please answer all questions, sign and date the form and return to me prior to or at the beginning of your first class. Please give any information that might be valuable to me in planning your yoga class and keeping you safe in your practice. You can view our full Privacy Policy at [www.1yoga.co.uk](http://www.1yoga.co.uk) for information on how your information will be used & stored.

### Contact details:

Name:

Address:

Email:

Mobile number:

Home phone number:

### About your Yoga experience:

Have you ever practised yoga before?

Details:

What is your main reason for coming to yoga classes?

- |                    |                          |               |                          |             |                          |
|--------------------|--------------------------|---------------|--------------------------|-------------|--------------------------|
| Exercise           | <input type="checkbox"/> | Relaxation    | <input type="checkbox"/> | Meditation  | <input type="checkbox"/> |
| Flexibility        | <input type="checkbox"/> | Pain Relief   | <input type="checkbox"/> | Weight loss | <input type="checkbox"/> |
| Spiritual practice | <input type="checkbox"/> | Stress Relief | <input type="checkbox"/> | Other:      | <input type="checkbox"/> |

### About your medical history:

**Do you have or have you ever experienced any of the following?**

- |                                     |                          |     |                          |    |
|-------------------------------------|--------------------------|-----|--------------------------|----|
| High / low blood pressure           | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Backache or pain                    | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Headaches, dizziness or fainting    | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Breathlessness / asthma             | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Diabetes                            | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Palpitations / heart problems       | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Allergies                           | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Mental health issues                | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Do you take any regular medication? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |

Details:

Have you had any significant medical conditions, injuries or operations?  YES  NO

Details:

### Personal declaration

***I declare that the above information is correct. I take responsibility to provide One Yoga with any further information that may affect my practice or of any changes to the above. I accept full liability for my own safety within my yoga practice.***

- I confirm that I have been made aware of One Yoga's privacy policy and know how to access this
- I consent to being contacted via mail / email / SMS / social media **[please circle]** regarding promotions and events directly related to One Yoga
- I consent to photos of me taken during class to be used on One Yoga's official social media sites and website

Print name:

Signature:

Date: