



Lexington Healing Arts Academy

# YOGA/Group Exercise

CONFIDENTIAL CLIENT INFORMATION

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Occupation \_\_\_\_\_

Have you taken Yoga/Group Exercise classes before? Yes \_\_\_\_\_ No \_\_\_\_\_

How did you hear of us? \_\_\_\_\_ Internet \_\_\_\_\_ Phone Book \_\_\_\_\_ Referral \_\_\_\_\_ Event \_\_\_\_\_ Gift \_\_\_\_\_ Ad \_\_\_\_\_ Other

I voluntarily participate in yoga and/or group exercise instruction with Lexington Healing Arts Academy (LHAA). By signing my name to this form, I release LHAA and its agents from liability for any injury to my person or damage to my property while on the premises. I have reported any restrictive physical disorders to the staff and/or teachers of LHAA.

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

Emergency Contact Person: Name \_\_\_\_\_ Phone \_\_\_\_\_

Package Type \_\_\_\_\_