



Yoga for Pregnancy Registration Form

Please complete this form and bring it to your first session.

Yorkshire Yoga & Therapy Centre

9-10 Halfpenny Close, Knaresborough HG5 0TG

All information is kept strictly confidential.

Name: _____

Address: _____

Phone: (*work and home*): _____

E-Mail (*please print legibly*): _____

Occupation: _____

Date of Birth: _____

Due date & planned place of birth: _____

GP/Midwifery practice: _____

Have you studied yoga before? Please give details of how long, what style of yoga etc.

Why have you come to learn yoga, and what do you hope to gain from it?

During this pregnancy, have you experienced any of the following? Please circle those conditions which have affected you.

Morning sickness

Headaches

Symphysis pubis dysfunction

Constipation

Heartburn

Breathlessness

Nosebleeds

Anaemia

Dizziness

Lower back pain

Sciatica

Aching groins

Varicose veins

Oedema (swollen joints)

Sleep disturbances

High blood pressure

Pre-eclampsia

Depression

Low blood pressure

Haemorrhoids

Anxiety

Bleeding

Pain from fibroids

Diabetes

Please give details of any of the above which you have circled, or any other health issues, which you feel may have some bearing on your yoga practice. Please use page overleaf if you need to.

Prior to this pregnancy, have you suffered any injury or undergone any surgery (e.g caesarean section, knee surgery) that may have some bearing on your yoga practice?

If so, please state details.

Previous pregnancies?

Previous miscarriages?

Previous births? Please give ages of children.

Do you smoke? ____ How many per day? ____ Drink alcohol? ____ How much? ____

Are you taking any form of medication that may have some bearing on your yoga practice?

If so, please state details.

How did you hear about these Yoga for Pregnancy classes? _____

Date

Your Signature