STUDENT INFORMATION

Please Print

NAME: _____ **EMAIL:** _____

HOME ADDRESS: _____
Street City/State/Zip

HOME PHONE: _____ **WORK PHONE:** _____ **EMERGENCY CALL:** _____
Name Phone

NEW STUDENT: Yes No If no, how many years studying yoga? _____ **Which Style?** _____

Have you studies Yamuna Body Rolling? Yes No How Long? _____

OCCUPATION: _____ **DATE OF BIRTH:** _____ **AGE:** _____ **SEX:** M F

Please circle areas of concern regarding your health.

Write pertinent details below or on the back of this sheet (such as when it started, what your symptoms are, etc.)

Allergy	Eyes	Liver	Post-Partum
Asthma	Gastrointestinal	Lower Back	Prolonged Illness
Ankles/Feet	Headache	Low Blood Pressure	Prostate
Arthritis	Heart Condition	Lyme's Disease	Recent Surgery
Auto-Immune	Heel Spur	Menopausal	Sedentary
Bladder	High Blood Pressure	Menstrual Problems	Sciatica
Carpel Tunnel	Hips/Legs	Multiple Sclerosis	Scoliosis
Chronic Fatigue	HIV-Related	Neck	Shoulders
Diabetes	Hypoglycemia	Osteoporosis	Thyroid
Depression	Kidney	Plantar Fasciitis	Wrist/Hand
Dizziness	Knees	Pregnancy	

Please describe conditions not listed above or elaborate on those circled. _____

_____

_____

Continue on back if necessary

Please list medications, remedies and supplements used: _____

_____

Have you used? (circle answers): ACUPUNCTURE CHIROPRACTIC CHINESE MEDICINE MASSAGE

DEEP TISSUE THERAPY HOMEOPATHIC MEDICINE PHYSICAL THERAPY PSYCHOTHERAPY

Have you ever been in a car accident or had a traumatic injury? Yes No If yes, what year? _____

How did you hear about the classes at BYS? _____

This form does not claim to treat any of the conditions listed above or any liability, loss, personal or otherwise, resulting from these programs.
Yoga or Yamuna Body Rolling instructions are in no way intended as a substitute for medical counseling.

Signature: _____ **Date:** _____