



Application for Birthlight Baby Yoga

I am interested in attending postnatal and baby yoga classes.

DATE:

NAME:

NAME OF BABY:

ADDRESS:

TELEPHONE:

EMAIL:

DATE OF BIRTH:

What is the date of birth of your baby?

Was this your first pregnancy? YES/NO

If not, how many children do you have?

Date(s) of birth of other child/children:

How did you first hear about us?

Once we start working with people we like to contact their general practitioner.
If you have no objection to this, please give your doctor's name and address below:

What is your present occupation?

Did you attend yoga classes during your most recent pregnancy? YES/NO

If yes, please give details:

Please give us a brief overview of your most recent birth. Let us know any complications that may have arisen and any medical interventions/procedures that took place:

Please let us know of any contraindications regarding your baby's health
e.g. clicky hips, downs syndrome, eczema, colic:

What is your baby's general disposition?

Have you received any treatment with complimentary or alternative practitioners?

YES/NO

Has your baby?

YES/NO

If YES please give details:

Are you or your baby currently on any medication? YES/NO

Please tick any of the following medicines you took (even once) in the past year:

- Laxatives
- Indigestion pills
- Antibiotics
- Painkillers – including aspirin
- Anti-inflammatories
- High blood pressure drugs
- Sleeping pills
- Tranquilizers

Please give details of any other medicines:

Are you suffering from any postnatal complications e.g. weak bladder, backache, headaches, piles? YES/NO

If YES please give details (*this information will help me to design a postnatal yoga programme to help with these ailments.*)

Thank you for completing this form. All information given is strictly confidential.

Signed: