



ANTE-NATAL YOGA REGISTRATION FORM

Please complete this sheet prior to commencing your first class. It will help us to give you the best support while you are learning and ensure that you gain the maximum benefit from your classes. All information supplied will be treated with the strictest confidence.

NAME:

ADDRESS:

DATE OF BIRTH:

OCCUPATION:

TELEPHONE:

MOBILE:

EMAIL:

MIDWIFERY PRACTICE:

DUE DATE AND PLANNED PLACE OF BIRTH:

Do you have any experience of yoga?

(If yes, please give details of the type of yoga you practised, for how long and when you stopped.)

Why do you want to learn yoga and what do you hope to gain from it?

Have you experienced any of the following during this pregnancy

(Please circle as appropriate)

Morning sickness	Headaches	Dizziness
Constipation	Heartburn	Breathlessness
Nosebleeds	Anaemia	Diabetes
Lower back pain	Sciatica	Aching joints
Varicose veins	Oedema (swollen joints)	
High blood pressure	Pre-eclampsia	Asthma
Depression	Anxiety	Sleep disturbances
Bleeding	Pain from fibroids	Low blood pressure

Please give on the next page of anything you have circled above, or any other health issues, which you feel may have some bearing on your yoga practise. Please also state if you have suffered any of the above in previous pregnancies.

(continued)

Prior to this pregnancy, have you suffered any injury or undergone any surgery (e.g. caesarean section, knee surgery), that could have a bearing on your yoga practise? *(if yes, please give details)*

Previous pregnancies?

Previous miscarriages?

Previous births? If so, please give ages of children.

Do you smoke? If so, how much?

Do you drink? If so, how much in an average week?

Are you taking any form of medication?
(if yes, please give details)

Have you received any treatment with complimentary or alternative practitioners?
(if yes, please give details)

Signature:

Date:

Thank you for completing this form. We look forward to helping you with your yoga practise.