BACKCARE YOGA CLASS REGISTRATION FORM

Name: Address:

Postcode: Occupation:

Email:

Phone:

Name of emergency contact: Emergency contact phone:

Name of G.P/Link Worker: Address/Phone:

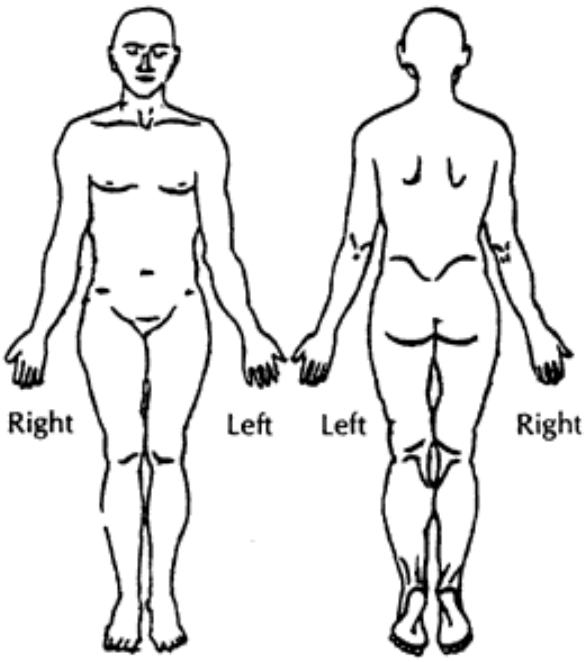
I am asking for these details and permission to contact these people in case of emergency only, and would never use them for any other reason

What are you hoping to gain from this yoga back care class?

How did you find out about the class?

What is your previous experience of yoga?

Please indicate on the body chart any areas of aching, pain, pins & needles or numbness.
If any of these are **constant,** please encircle that area.



Please provide details of any conditions and/or ailments relating to your physical and mental health including any injuries you have (either long standing or recent):

If you have a problem with your back or neck, what is your understanding of it?

How long have you been experiencing these problems?

Have you ever been given a diagnosis of back or neck pain? Yes ☐ No ☐

If yes, please describe.

Who gave you that diagnosis?

Have you had any medical treatment for your back, including physiotherapy, osteopathy or chiropractic?

Are you currently receiving treatment? Yes ☐ No ☐

Are there any specific movements that trigger your symptoms? If so, please state:

Are there any specific movements that ease your symptoms? If so, please state:

Do you have any of the following symptoms due to your back condition?		
Numbness, weakness, pins and needles in both legs	Yes ☐	No ☐
Numbness in your inner thighs and around your genitals	Yes ☐	No ☐
Unsteadiness on your feet	Yes ☐	No ☐
Loss of control or feeling around your bladder or bowels	Yes ☐	No ☐
Have you had any unexplained weight loss?	Yes ☐	No ☐

Personal health history (tick any that apply)

- ☐ Spinal disc or stenosis
- ☐ Heart
- ☐ Rheumatoid Arthritis
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Fatigue
- ☐ High or low BP
- ☐ Hernia (type)
- ☐ Breathing
- ☐ Hearing / Visual
- ☐ Menopause
- ☐ Joint problems (name)

☐ Anxiety, depression, stress issues, PTSD or any other mental health problems

Any other?

Are you or have you recently been pregnant? Yes ☐ No ☐

If you have ticked any of the above, please give *brief* details:

Are you taking any medication? If yes, please give details:

In this class we will be doing exercises in a variety of different positions:

Are you able to get up and down from the floor independently?	Yes ☐	No☐
Are you able to lie on your back for 10 minutes?	Yes ☐	No☐
Are you able to lie on your front for 10 minutes?	Yes ☐	No☐
Are you able to be on all fours, hands and knees?	Yes ☐	No☐

(positions can, of course, be adapted for comfort)

Signed: Date: