True Touch Therapy

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Health Survey/Waiver Form

Name:_____
Address:_____
City:_____
Phone Number:_____ Date of Birth:_____
Email:_____

Do you have any special health problems?_____
_____
_____
_____
Do you have high blood pressure?_____
Do you have low blood pressure?_____
Is your blood pressure under control presently?_____
Do you have a thyroid problem?_____
Do you have diabetes?_____
Are you taking any medication regularly & what?_____
_____
_____
_____
Have you had recent surgery?_____
Do you had any joint pain and where?_____
_____
Do you have any back pain? If so, where?_____
_____

How many hours a week do you devote to physical activity?_____
What physical activity do you presently participate in and what?_____ __
_____
_____
Would you consider your flexibility – poor, moderate or advanced?_____
_____

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What do you hope to gain from taking yoga?_____
_____

Please inform the teacher before any class of any new injury or pain and please feel free to call or email anytime regarding any yoga-related questions.

Acknowledgement and waiver:

I_____ declare the above information to be accurate and true. I acknowledge that I understand that Yoga is not a medical procedure and that the practitioner will not be providing diagnosis of any integration intended to facilitate wholeness, body awareness and self-awareness. I also understand that I am solely responsible for my health, safety and well-being and agree to assume the risk of such exercise and further agree to not hold the Yoga Practitioner, Tracey Pike for any and all claims, suite, losses or related causes of action for damages, including, but not limited to, such claims that may result from my injury or death, accidental or otherwise, during or arising in anyway from yoga or movement. I agree to inform the Practitioners of any activity or movement which I can not safely perform and will not perform any activity or movement, which I feel is likely to cause me to injure myself.

In signing this consent form, I affirm that I have read this form in its entirety and that I understand the nature of the treatments and programs I have registered for. I also affirm that my questions regarding the program have been answered to my satisfaction. In the event that a medical clearance must be obtained prior to my participation in the exercise program, I agree to consult my Physician and obtain written permission from my Physician prior to the commencement of any treatment of exercise program.

Dated:____________________ Signed:________________________________