Karuna Health

Client Information

Name_____ Date _____

Address_____

City_____ State_____ Zip_____

Date of Birth _____ Age _____ Occupation _____

Cell Phone _____ Home Phone _____

Work Phone _____ Referred by _____

Email Address (this is not shared; it is for the purpose of receiving updates/newsletters from Karuna Health only)

_____

Emergency contact_____ Phone _____

What are your goals in practicing yoga?

What are the repetitive postures/motions that you perform at work/other setting?

What are your exercise activities?

Please list any current medications and their purposes:

Karuna Health

Yoga Informed Consent and Agreement

I agree that I am participating in yoga classes, workshops, practices or demos offered by Karuna Health, Yuki Tsuji-Hoening during which I will receive information and instruction about yoga and health. I recognize that yoga requires physical exertion that may be strenuous and may cause physical injury; I am fully aware of and accept full personal responsibility for the risks and hazards involved. I understand that it is my responsibility to consult with a physician prior to and regarding my participation in the yoga classes, workshops, practices or demo. I represent and warrant that I am physically fit and I have no medical condition that would prevent my full participation in the yoga classes, workshops, practices or demos. In consideration of being permitted to participate in yoga classes, workshops, practices or demos, I agree to assume full responsibility for any risks, injuries, or damages, know or unknown, past present or future, which I might incur as a result of participating in any yoga classes, workshops, practices or demos. In further consideration of being permitted to participate in yoga classes, workshops, practices or demo, I knowingly, voluntarily and expressly waive any claim I may have against Karuna Health, Yuki Tsuji-Hoening, for any injury or death causes by their negligence or other acts. ***I have read the above release and waiver of liability and fully understand its contents. By signing my name below, I voluntarily agree to the terms and conditions stated above.***

Signature _____ **Date** _____

Karuna Health

Medical History

Please check all that apply to you
(Specify whether currently or previously)

Muscular-Skeletal

____Headaches
____Joint stiffness/swelling
____Broken/Fractured Bones
____Strains/Sprains
____TMJ Dysfunction
____Tendonitis
____Bursitis
____Sciatica
____Arthritis
____Osteoporosis
____Scoliosis
____Shoulder dislocation
____Whiplash
____Knee surgery
____Hip replacement
____Other_____

Nervous System

____Numbness/Tingling
____Sleep disorders
____Cerebral Palsy
____Epilepsy
____Chronic Fatigue
____Parkinson's Disease
____Spinal cord injury
____Carpal Tunnel Syndrome
____Thoracic Outlet Syndrome
____Disc herniation
____Other_____

Circulatory/Respiratory

____Dizziness/Fainting
____Varicose veins
____Blood clots
____Stroke
____Heart condition
____Allergies
____Asthma
____Low/High blood pressure
____Other_____

Digestive

____Diverticulosis
____Irritable Bowel Syndrome
____Crohn's Disease
____Colitis
____Adaptive Aids
____Diabetes
____Other_____

Other

____HIV
____Fibromyalgia
____Hearing impaired
____Visually impaired
____Surgeries_____
____Drug use_____
____Infectious disease_____
____Depression_____
____Other_____

Reproductive

____Pregnancy
____Menopause
____Pelvic Inflammation Disorder
____Endometriosis
____Hysterectomy
____Cesarean Section
____Other_____

The information provided above is accurate to the best of my knowledge.

Signature_____ **Date**_____