Genesis Behavioral Health

Yoga ~ Meditation/Relaxation ~ Personal and Group Classes

Name: _____ Date: _____

Telephone: _____ Email: _____

Date of Birth: _____ Height: _____ Weight:_____

In Case of Emergency Contact: _____

Phone #:_____ Relationship: _____

Physician: _____ Specialty:_____

Address: _____ Phone: _____

Are you currently under a doctor's care? Yes No
If yes, explain:

_____

_____

_____

Have you been recently hospitalized? Yes No
If yes, explain: _____

Any known Allergies? Yes No
If yes, explain:_____

Do you smoke cigarettes? Yes No

Are you pregnant? Yes No

Do you drink alcohol? Yes No If so, how much? _____

How would you rate your stress level? (select one): Low Medium High

How active are you during an average week? (select one): Low Medium High

Type of activity? _____

*Please list below barriers (if any) that may prevent or alter an activity plan :

_____

Do you have any of the following conditions:

High blood pressure? Yes No

High cholesterol? Yes No

Diabetes? Yes No

Known heart disease? Yes No

A heart murmur? Yes No

Chest pain with exertion? Yes No

Irregular heart beat or palpitations? Yes No

Lightheadedness or Unusual shortness of breath? Yes No

Other metabolic disorders (thyroid, kidney, etc.)? Yes No

Epilepsy? Yes No

Asthma? Yes No

Back pain: upper, middle, lower? Yes No

To the best of my knowledge, the above information is true and correct.

Printed Name: _____

Signature: _____

Date_____