

Questionnaire & Registration Form for Yoga for Survivors Class

Name _____ Phone # _____ Date _____

Address _____ City _____ Zip Code _____

Email address _____ DOB _____

Emergency Contact _____ Phone # _____

Diagnosis (include type of cancer, stage, and lymph node involvement)

Date of Diagnosis _____

Oncologist _____ Surgeon _____

Date of last chemotherapy? _____ How many treatments remain? _____

Date of last radiation? _____ How many treatments remain? _____

Please describe any side-effects you are currently experiencing from radiation, chemotherapy, other therapies, or any medications you are taking:

Please list all cancer-related surgeries, as well as any other major surgeries you have had

Date _____ Type of surgery _____

Date _____ Type of surgery _____

Date _____ Type of surgery _____

Date _____ Type of surgery _____

Date _____ Type of surgery _____

Date _____ Type of surgery _____

Date _____ Type of surgery _____

Please describe any limitations/side-effects you are currently experiencing from any of the surgeries you have had:

Please list any other health problems you are experiencing, particularly those for which you are:
1) taking medication, and/or 2) being monitored (on an occasional or regular basis) by a doctor

Aside from what you have already listed, do you have any other limitations in your physical activity level, or any movements that cause you pain?

If you are interested in restoring strength and flexibility to a particular area of your body, please describe here:

Are you able to do the following with relative ease and comfort?

Stand	Lie on your right side	Breathe through your nose
Lie on your back	Lie on your left side	
Lie on your stomach	Sit	

Aside from what you have already listed, has your doctor ever said that you should modify your physical activities, or restrict/limit your movements in any way? If so, please describe:

Have you practiced yoga before? If so please describe:

What are your goals for participating in this class?

Do you have any special concerns about participating in this class?

How did you find out about this class?

HealthLinks	Tree House Yoga Center
Doctor's Office (name _____)	Longmont United Hospital
Friend (name _____)	Other _____

I _____ (print name) understand that yoga includes physical movements as well as an opportunity for relaxation, stress re-education and relief of muscular tension. As is the case with any physical activity, the risk of injury, even serious or disabling, is always present and cannot be entirely eliminated. If I experience any pain or discomfort, I will listen to my body, adjust the posture and ask for support from the teacher. I will continue to breathe smoothly.

Yoga is not a substitute for medical attention, examination, diagnosis or treatment. Yoga is not recommended and is not safe under certain medical conditions. I affirm that I alone am responsible to decide whether to practice yoga. I affirm that my platelet count is at least 20,000 and all surgical incisions on my body have healed. I hereby agree to irrevocably release and waive any claims that I have now or hereafter may have against Laura Kupperman, any other Yoga for Survivors teacher, or the facility where class is held.

Signature of student, parent or guardian

Date