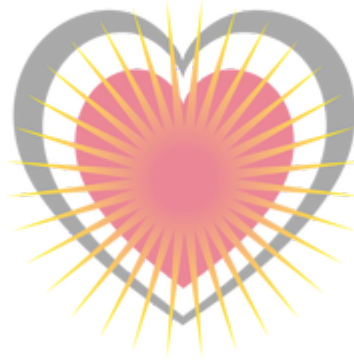


Relax ♥ Release ♥ Transform



Date- _____

Name- _____

Address- _____

Email- _____ Cell Phone- _____

1. Do you have anything going on in your body right now? _____

2. How is it effecting your life? _____

3. Are you currently under the care of a health practitioner? _____

4. Do you have medical clearance to do yoga? _____

5. Do you have any restrictions in movement? _____

6. Can you get up and down off the floor without assistance? _____

7. How would you rate your stress level? High _____ Moderate _____ Low _____ None _____

8. Are you happy and passionate about your life? _____

9. Do you exercise? If so, what do you do and how frequently? _____

10. Do you meditate? If so, how often? _____

11. Do you currently do any yoga and if so what style? _____

-
12. How often do you practice? Daily ____ Every few days _____ Every other week ____ Whenever I feel like it _____
13. How do you feel after you do your current style of yoga? _____
-
-
14. How willing are you to change your current lifestyle? _____
15. How willing are you to change your current style of yoga? _____
16. What are you looking for out of Svaroopo Yoga? _____
-
-
-
-

Consent, Waiver and Release Policy-

I understand that Yoga and Yoga Therapy is a dynamic process that opens and moves energy within the entire body and mind. I understand that Yoga and Yoga Therapy is not meant to diagnose or treat any illness, disease, physical or mental disorder, injury or condition. I will take full responsibility for my health, wellbeing and happiness.

Client Signature _____ Date _____

To the best of my knowledge, I am in good health and have no known medical problems that would restrict my ability to participate in this yoga program. I am aware that physical exercise and yoga may cause injury. I agree to waive any claims or rights to sue Kim or Paul Zikmund for personal injury as a result of these activities. I understand that it is always advisable and recommended to consult my physician before undertaking this or any yoga program. Thank you!

By signing here, I agree to the Waiver and Release Policy

Client signature _____ Date _____

Kim Zikmund _____

If physician's approval is recommended, please have doctor sign and return a consent to participate

Physician signature _____ Date _____