Name:_____ Date:_____

Email Address: _____

Cel Phone : _____ Date of Birth: _____

Street Address:_____

Postal Code: _____ City: _____ Country:_____

Emergency Contact Name _____ Phone # _____

1: What Languages do your Speak & Understand? _ English _ Spanish

2: Have you taken Yoga or Meditation classes in the past? _ Yes _No If Yes, how long and what style?

3. Do you have any past injuries? If so, Please specify:

4. Have you had surgery? How long ago? Specify:

5. Are you presently under the care of a physician, psychologist, or chiropractor? If so, Please state reason:

6. Are you presently experiencing stress? (job, family, health, environment, other) Please Specify:

7. Are you currently Pregnant?

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8. Do you have any of the following:

_ Scoliosis _ Back Problems _ Spinal Abnormalities
_ High/lLow blood pressure m _ Arthritis _ Diabetes _ Allergies
_ Hernia _ Migraine Headaches _ Visual or Hearing deficient
_ Asthma _ Heart problems _ Head, Neck, back Pain
_ Physical Disabilities
_ Other :Please Specify _____

I understand that Rayo de la Vida SL is here to serve me by sharing knowledge of exercise and health. I agree to take full responsibility for not exceeding my personal physical limits in my practice and for any injury I might suffer during my participation in class or any activity with Rayo de la Vida. It is my responsibility to ascertain that there is no reason which would prevent my participation. I acknowledge that the class given is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing strength, flexibility, circulation and energy flow. Because the yoga instructor must be aware of existing conditions, I have stated all my known medical conditions and take it upon myself to keep the yoga instructor updated on my physical health. I waive any claim that I might have at any time for injury of any sort against Rayo de la Vida SL, its leaseholder, instructors, or any person or entity in any way involved therewith. I have carefully read this release. I fully understand and agree with its contents. All medical information written on this questionnaire remains confidential.

Signed: Date: