

OSHER CENTER FOR INTEGRATIVE MEDICINE  
YOGA REGISTRATION/ HEALTH HISTORY FORM

**General Information**

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Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: Day time ( ) \_\_\_\_\_ Evening ( ) \_\_\_\_\_

CRC Gentle Yoga Thursdays, 1:30pm-3:00pm

Yoga for Medical and Stress Related Conditions. Date: \_\_\_\_\_

**Form of Payment:**

Charge: Visa/Master Card

Check: Please make payable to UC regents. Please see policy below.

Card Number \_\_\_\_\_

Exp. Date \_\_\_\_\_

Card holder's signature \_\_\_\_\_

Name as it appears on card \_\_\_\_\_

**To Register:**

**In Person:** Pay with Visa, Master Card or check(s) payable to **UC Regents**. Please return to:  
Osher Center for Integrative Medicine, 1701 Divisadero, Suite 150, San Francisco, CA 94115

**By Fax:** Include Visa or Master Card number, expiration date & signature.  
A receipt will be mailed to you. **Fax: (415) 353-7358**

**By Mail:** Pay with Visa, Master Card or check(s) payable to **UC Regents**. Please do not send cash.  
Send to Osher Center for Integrative Medicine, Clinical Programs  
ATTN: Class Registration, UCSF Box 1726, San Francisco, CA 94143-1726

**Payment Policy:**

- Checks must be pre-printed, drawn on a California bank and must include complete address, telephone, and driver's license #.
- A refund or credit less a \$10 cancellation fee will be gladly given when requested at least 5 days before 1<sup>st</sup> class.
- Returned check fee is \$25.

**Participation Policy:**

A physician Medical Release is required to be filled out prior to your first class and is part of our registration process. The form is in this packet (last page). Please have this form completed and fax ahead to our clinic (415-353-7358) or bring completed forms with you the first night of class.

**FOR OFFICE USE ONLY:**

Date Entered \_\_\_\_\_ Check # \_\_\_\_\_ Amount \_\_\_\_\_ Receipt # \_\_\_\_\_

Staff initials \_\_\_\_\_ Comments \_\_\_\_\_

## Medical Information

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Medical Condition \_\_\_\_\_

Physician's name \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_

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*Please check if you have or have had any of the following:*

OCCURRENCE OR CONDITION	X	DATE OR TIME PERIOD
heart attack, coronary angioplasty or cardiac surgery		
chest discomfort		
lightheadedness or fainting with exercise		
shortness of breath with exercise		
rapid heart beats or palpitations		
heart murmurs, clicks or unusual cardiac findings		
high blood pressure		
stroke		
ankle swelling		
numbness, tingling or loss of feeling in hands or feet		

OCCURRENCE OR CONDITION	X	DATE OR TIME PERIOD
peripheral arterial disease, claudication		
phlebitis, emboli		
pulmonary disease including asthma, emphysema and bronchitis		
diabetes		
low blood sugar		
thyroid condition		
high cholesterol		
anemia		
arthritis (indicate where)		
family history of coronary artery disease		

Please list all medication that you are currently using

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Indicate any orthopedic problems you might have

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### *Exercise History*

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*Please check if you have participated in any of the following in the past 6 months:*

ACTIVITY	X	FREQUENCY	DURATION
aerobic dance			
swimming			
walking			
jogging/running			
bicycling			
tennis or golf			
weight training			
stretching			
other (indicate type)			

Do you know your average heart rate during exercise?

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**OFFICE USE ONLY:**

Reviewed by: \_\_\_\_\_

Signature: \_\_\_\_\_

***Informed Consent***

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You will be participating in a therapeutic yoga class. This class is designed to be safe and comfortable for you to help you identify routines, which you can incorporate into your daily living. It is not intended as a rigorous workout, but will help you establish a program to restore strength, and gain flexibility and endurance. We expect that this activity will make you feel better, but there exists the possibility of certain adverse changes occurring during the sessions. These include abnormal blood pressure, fainting, disorders of heartbeat, and in rare instances, heart attack, stroke or death. Every effort will be made to tailor these programs to your physical limitations and to minimize these risks. Trained personnel are available to deal with unusual situations that may arise.

***Responsibility of the Participant***

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Take your time, relax and enjoy this.

**DO NOT** overdo it.

**DO NOT** withhold any information regarding symptoms from the medical professionals during the class.

**DO NOT** exercise when you do not feel well.

**DO NOT** exercise or practice yoga within 2 hours after eating.

**DO NOT** exercise or practice yoga after drinking alcoholic beverages.

**DO NOT** use extremely hot shower, sauna or steam bath after exercising.

**DO NOT** stretch beyond muscle tension to pain.

**DO** report any unusual symptoms that you experience before, during or after the sessions or you notice in an exercising colleague.

Your participation in this program is voluntary. You are free to withdraw if you so desire, both now and at any point in the program.

I acknowledge that I have read this form in its entirety or it has been read to me and that I have been given instructions on exercise guidelines and signs and symptoms of exercise intolerance. I accept the rules and regulations set forth. I consent to participate in the Therapeutic Yoga for Medical and Stress Related Conditions Program.

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Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

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*Signature of participant*

*Date*

*Witness*

# Medical Release for Participation in Group Yoga Programs

**Requestor Contact Information:**

Participant's Name: \_\_\_\_\_

Provider Name \_\_\_\_\_

Department: \_\_\_\_\_ Box #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relevant Clinical Information: \_\_\_\_\_

Please check any that apply to participant:

- |  |  |
|--|--|
| <input type="checkbox"/> Skin fragility due to debility, or anti-coagulation | <input type="checkbox"/> Hemophilia                |
| <input type="checkbox"/> Thrombocytopenia, coagulopathy                      | <input type="checkbox"/> Bone metastasis           |
| <input type="checkbox"/> Area of infection or inflammation                   | <input type="checkbox"/> Site of injury or surgery |
| <input type="checkbox"/> Abscess, skin lesion, active arthritis              | <input type="checkbox"/> Unstable spine            |
| <input type="checkbox"/> Acute or chronic muscular-skeletal conditions       |  |

I acknowledge that I am currently involved in the treatment of the above patient and that I know of no medical condition which would preclude their participation in the Therapeutic Yoga for Medical and Stress Related Conditions Program.

Signature of attending physician

Date

***\*Please note- this release is required prior to starting yoga program. Please bring form with you prior to first class or you may fax it to 415-353-7358. Thank you!***