Chronic Disease Management and Pain Management
Call 250-331-8502 to register and email this completed form to
CVNCCDM@islandhealth.ca

Intake Form Group Yoga Therapy Classes

Participant Information:			
Full Legal Name:		Preferred Name:	
Date of Birth:		Phone number:	
Address:			
Email address:			

Physical History: (Please check all that apply)		
Please review the conditions and check the ones that have affected your health either recently or in the past. Further explanations can be provided below.		
☐ diabetes	☐ broken/dislocated bones	☐ depression
☐ insomnia	☐ arthritis, bursitis	☐ heart conditions
☐ asthma, short breath	☐ seizures	☐ muscle strain
☐ numbness anywhere	☐ high blood pressure	☐ muscle sprain
☐ tingling anywhere	☐ low blood pressure	☐ osteoporosis
☐ stroke	☐ anxiety	☐ disc/ back problems
☐ pregnancy (if current, # of weeks) (if within the past 12 months, how many months since delivery?		
☐ surgery (explain here)		
☐ cancer (explain here)		

Is there anything else, which needs further explanation, or anything else you'd like to share (current injuries, discomforts, concerns, etc.)?

What would you like to gain most from these classes? Is there something specific you would like to have addressed?

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Emergency Contact:	

☐ I understand my participation is voluntary, and my information is stored/registered with Island Health.

☐ I understand that if I miss a class, I will be on standby/on a drop-in basis for the Gentle Chair Yoga Classes.

Printed Full Name: _____

Signature: _____

Date: _____