

ACTIVE BIRTH YOGA

REGISTRATION FORM

Confidential - for our records only.

Please feel free to leave any questions unanswered, if you prefer. Continue overleaf if necessary

Name..... Due Date

*Address

.....Post Code

*Home Tel..... *Work Tel*Mobile

*Email Address

*Please circle how you would prefer to be contacted

Your age 1st/2nd/3rd/? Baby? Ages of children?

ProfessionAre you planning to go back to work?

Where do you plan to give birth?Are you happy with this choice?

Who will be attending the birth?

Are you interested in water birth? Do you intend to *breast/*bottle feed?

*** PLEASE CIRCLE YOUR CHOICE**

How is your general health?

Any problems? Pubic pain Varicose veins Back pain Nausea Tiredness

Anxiety Depression High blood pressure Low blood pressure Low placenta

Anaemia Bleeding Constipation Heartburn Sleeplessness Numbness

Restless legs Breathlessness Haemorrhoids Leg cramps

Other problems/Allergies?.....

Obstetric/Gynae History: Miscarriages Terminations

Complications: present or previous

Operations Past injuries

Class preference: *Mon 7.30 - 9pm *Tues 12.15 - 1.45pm *Tues 7.30 - 9.00pm

* PLEASE INDICATE PREFERENCE BY INSERTING 1 - 3 IN THE BOXES. 1 - MOST PREFERRED 3 - LEAST PREFERRED OR PUT A CROSS IF YOU CANNOT ATTEND ANY PARTICULAR CLASS.

What date would you like to start?

How did you find out about the class?

PLEASE BE AS SPECIFIC AS POSSIBLE

I agree, for my own safety and well-being, to inform the teacher at the beginning of any class, should any changes in the above information occur, or if any medical, physical, or emotional problems should arise at any time during my Active Birth preparation.

Signed Date