



Blissful Yoga & Massage, LLC.
Medical Consent Form

Name _____ Age _____

Address _____

Telephone _____ Cell Phone _____ Email Address _____

Are you presently taking any prescription medications? **YES** **NO**
If yes, list the name of the medication and reason for taking it.

If you have undergone treatment or surgery for any of the following conditions during the last five years, please indicate by checking in the space provided.

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Carpal Tunnel Syndrome |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Depression | <input type="checkbox"/> Degenerative Joint Disease |
| <input type="checkbox"/> Low/High Blood Pressure | <input type="checkbox"/> Spinal Injury | <input type="checkbox"/> Back or neck injury or surgery |
| <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Sciatica | |

Are you currently under treatment for any of these conditions? If so, which ones?

Please list any condition not mentioned for which you are receiving medical treatment:

Allergies: **YES** **NO**
If yes, please list allergies: _____

I certify that the information I have provided is true and complete to the best of my knowledge and I do not hold **Blissful Yoga & Massage, LLC** and **Inez Powell**, its affiliates or instructors liable for any injury or mishaps arising from my participating in the _____ Yoga Class.

Signature _____ Date _____

If you are presently under medical treatment you are also required to sign below. Your signature indicates that you have permission from your physician to participate in a Yoga class.

Signature _____ Date _____