Vinyasa Flow Yoga Teacher Training

With Christina Newman

200HR Course

2015

Application Form

Please return completed form, questionnaire and payment (or $250 deposit) by July 18th, 2015 to: Directly to Christina Newman (www.christinanewman108.com) or The Kore Pilates & Yoga Studio. All responses are strictly confidential.

Name:

_____

Address:

_____

Phone Number: Primary # _____Secondary # _____

Day of Birth: _____ Email: _____

Emergency Contact: _____Phone #: _____

How did you hear about this program? _____

Why are you interested in the teacher-training program?

_____

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Tell us about your yoga practice:

How long have you been practicing yoga?

Which type of yoga do you practice?

Who have been your main teachers or sources of information?

Describe your current spiritual and physical practice.

What is your educational and professional background outside of yoga?

How do you see yourself applying this training in your life and/or community?

In what ways has yoga made shifts or transformations to your life?

Health Experiences Information Form

All responses are confidential. We use this information only to better assist you during the program, not to screen participants (participation is this portion is optional and may be also be conducted privately in person). Attach additional sheets if necessary.

1. Briefly describe your overall health.

2. Describe any history (include dates) of back/spine/neck problems and indicate whether they still give you problems. Please be specific.

3. Describe any history (include dates) of joint problems (knee, hip, shoulder, wrist, ankle, etc) including joint repair/ replacement surgeries. Please be specific.

4. Blood pressure (circle one): HIGH / LOW / NORMAL When was it last checked?

_____

5. Describe any history of cardiovascular problems. If you don't have any cardiovascular problems but are
considered to be "at risk", then please indicate this as well.

6. Circle any of the following difficulties you have had (or have) and explain the relevant specifics:

Diabetes Osteoporosis-Osteopenia Chronic Headaches Ulcers Stroke Seizures Allergies
Asthma Cancer Frequent Dizziness Other:

_____

7. Women: are you pregnant? YES / NO If so, when is your baby due?

_____

8. Do you have any other limitations/dietary restrictions, or health conditions? YES / NO If yes, what conditions?

_____

9. Are you currently seeing a physician or a therapist for any physical conditions? YES / NO If yes, what conditions?

_____

10. Are you taking medication for any physical or psychological conditions? YES / NO If yes, what medications are taken for what conditions and at what frequency?

_____

11. If you have any learning disabilities or other special physical or psychological circumstance, please explain below so we can better serve you during the program.

I hereby certify that the above information is correct to the best of my knowledge.

Date
Participant's Name (print)

Participant's Signature