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ANTENATAL CLASS REGISTRATION FORM

All the information given will be treated in the strictest confidence

Name & address

Email:

Phone:

Date of Birth:

First yoga class: Yes / No

Due date & planned place of birth:

Midwifery practice:

During this pregnancy, have you experienced any of the following? (please circle)

Morning sickness	Headaches	Dizziness
Constipation	Heartburn	Breathlessness
Nosebleeds	Anaemia	Diabetes
Lower back pain	Sciatica	Aching groin
Varicose veins	Oedema	High blood pressure
Pre-eclampsia	Depression	Anxiety
Bleeding	SPD	Sleep disturbances

If you circled any of the above please give further details if you feel it is appropriate.

Prior to the pregnancy, have you suffered and injury or undergone any surgery that may have some bearing on your yoga practice? If so, please give details.

Previous miscarriages?

Previous births?

Are you taking any medication that may have some bearing on your yoga practice? If so, please give details.

How did you hear about the class?

THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS FORM.

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