**FORM #1**

Name: ____________________________________________________
Date:____________________________
Address:
Street:_______________________________________________________________________
________

City: ______________________________________ State:_______________
Zip:____________________

Phone:_____________________________Email:____________________________________
______________

Would you like to receive our newsletter (Once a month max; we don't sell addresses or spam):
Yes ◯ No ◯

Emergency Contact:
___________________________________________________________________________

Emergency Contact
Phone:_____________________________Relationship:_____________________________
_

Do you require any type of accommodations to make you feel safe and/or comfortable? Yes ◯
No ◯

If yes, please list/explain:
________________________________________________________________________
___________________________________________________________________________

Are you currently taking medications (Rx or over the counter) that may cause side effects that we should know about?

Yes ◯ No ◯ If yes please explain:
_______________________________________________________
___________________________________________________________________________
______________

Are you pregnant? Yes ◯ No ◯ Do you have any allergies Yes ◯ No ◯ Sensitivities? Yes ◯ No ◯

Please review this list and check those conditions that have affected your health. The list includes conditions that may have recommended modifications during a Yoga practice. You may share any other conditions not listed if you are concerned and would like suggestions.

____Surgery in past year: ______________________________________________date:________________________

____Hiatal Hernia ____Seizures ____Blood Clots ____Muscle strain/sprain

____Whiplash; date: ____ High or ___Low Blood Pressure; if yes, do you take medication for HBP?___Y ___N

*If any of the above need to be detailed, please describe*: _____________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

## FORM #2:

**PLEASE READ CAREFULLY – THIS IS A LEGAL DOCUMENT THAT AFFECTS YOUR LEGAL RIGHTS**

This Release and Waiver of Liability (the "***Release***") is executed on (*date*)_________________________ By "Participant" (*participant name*)___________________________________________________________,

In favor of Wholistic Yoga Center LLC, 138 S Main St, Shawano, WI 54166, Faculty, Teachers, Guest Speakers, Assistants, Substitutes, Venue Owners and Representatives, and their Directors, Officers, Employees, Volunteers, Family Members and Agents (collectively, "WYctr"). I desire to participate in the OVERCOME! Clinic and engage in activities related to the training including, but not limited to, participating in Yoga classes, practicing meditation, breathwork and Yoga postures, participating in group learning activities, lectures and other experiential exercises (collectively, the "***Activities***"). I hereby freely, voluntarily and without duress execute this ***Release*** under the following terms:

**Release & Waiver.** I, (participant *name*)_______________________________________________________,
do hereby release and forever discharge and hold harmless ***Wholistic Yoga Center*** and their successors and assigns from any and all liability, claims and demands of whatever kind or nature, either in law or in equity, which arise or may hereafter arise from my ***Activities*** with ***Wholistic Yoga Center***.
I understand and acknowledge that this Release discharges ***Wholitic Yoga Center*** from any liability or claim that I may have against ***Wholistic Yoga Center*** with respect to any bodily injury, personal injury, illness, death or property damage that may result from my ***Activities*** with ***Wholistic Yoga Center***. I also understand that ***Wholistic Yoga Center*** do not assume any responsibility for, or obligation to provide financial assistance or other assistance, including but not limited to medical, health or disability insurance in the event of injury, illness, death or property damage.

**Assumption Of Risk**. Yoga and other ***Activities*** includes physical movements as well as an opportunity for relaxation, stress re-education and relief of muscular tension. Participation in OVERCOME! Clinic includes, but is not limited to, participation in meditation techniques, yogic breathing techniques, and performing various yoga postures, group activities, lectures and/ or other experiential style learning exercises. Yoga is an individual experience. As is the case with any physical activity, the risk of injury, even serious or disabling, is always present and cannot be entirely eliminated. If I experience any pain or discomfort, I will listen to my body, adjust the posture and ask for assistance. I understand that it is my responsibility to progress at my own pace and appropriate level in yoga class. Yoga is not a substitute for medical attention, examination, diagnosis or treatment. Yoga is not recommended and is not safe under certain medical conditions. I understand that Yoga is not a substitute for medical care. I acknowledge that participation in yoga classes exposes me to a possible risk of personal injury. I am fully aware of this risk. I understand that my safety is my responsibility.

I hereby certify that I have read this document and I understand its content. I am aware that this is a release of liability as well as a contract and I sign it of my own free will.

Participant Signature:_____________________________________________________________ Print Name:
_____________________________________________Date:____________________

**FORM #3b:**

*Questionnaire for "Overcome!": A Natural & Holistic Approach*

All of these questions are optional. We use the information to try our best to customize our program to fulfill the needs of the class participants. This information is confidential and will only be viewed by the facilitator.

Do you have any allergies? We may use Essential oils (not synthetic fragrances); please let us know if you are sensitive to: Lavender, Frankincense, Rose, Clove, or sandalwood. Please list any sensitivity that you have:

What brings you to our Overcome! Clinic? Please describe how you feel and/or act that is troublesome for you (we'll call these "troublesome symptoms" for the remainder of the questionnaire).

How long have you noticed the troublesome symptoms you described above?

Have you ever experienced a panic attack? *circle one:* **YES NO** If

yes, how often and when was the last one?

Do you feel that anxiety is present in your everyday life? *circle one:* **YES NO**

Do you experience the following: troublesome sypmtoms? *Please circle all that apply:*

| | | |
|---|---|---|
| Insomnia | Night sweats | Irritability |
| Headaches | Nausea | Fatigue |
| Excessive worry | Chronic Health related concerns | Shakiness |
| Heart palpitations | Chronic negative thinking | Difficulty concentrating |
| Fear of leaving your home | IBS or other GI issues | Excessive sweating |

If you want to add any other symptoms that you want to address in this clinic (if possible), please write below:

Have you tried a lot of different things to resolve the troublesome symptoms? *circle one:* **YES NO**

If yes, please list what you have tried in the past:

Do you believe in your ability to self-heal? *circle one:* **YES NO**

Can you imagine what your life will be like when you conquer the troublesome symptoms? *circle one:* **YES NO**

Who (person or group) feels like a support network for you (friends, partner, church group and/or family)?

How often do you exercise? What form of exercise and how often?

How did you hear about our program?

If you are here for medication step-down support (to manage withdrawal symptoms) please answer the following:
*****Do not stop taking any medications without the consent and supervision of your healthcare provider. If you are here for stepdown support, you must be under the supervision of a prescribing healthcare professional****

Are you currently taking medications? *circle one:* **YES NO** If yes, how long have you been taking them? _________

Please describe the symptoms you experience that you believe are due to your step-down program.

What are your expectations from this program?