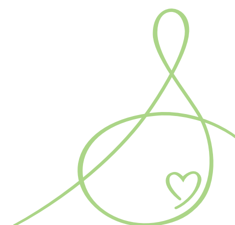
REGISTRATION FORM

Thank you for choosing to come to this practice.

To help us support you in the best way, could you please complete this form in the comfort of knowing that all information is kept strictly confidential. Your privacy and sense of safety is paramount to us.



SHARON KEMPTHORNE
RESTORATIVE THERAPEUTICS

Name:	Date of Birth:
Address (including postal code):	
Phone: Home	Mobile
Work	Email:
Occupation:	
Emergency contact:	Emergency phone number:

How did you hear about us? (please tick) Online ☐ Referral ☐ Promotional Flyer ☐ Friend ☐ Other ☐

(Please give details):

ACTIVITY

What are your current or recent physical activities/practices?

Have you ever practiced yoga before? If yes, for how long and any particular style? ☐ Yes ☐ No

Have you ever meditated before? If yes, how often? ☐ Yes ☐ No

What would you like to experience as a result of this session(s)? (Please tick)

☐ Stillness ☐ Relaxation ☐ Stress Management ☐ Fertility Support ☐ Inner calm/peace

☐ Women's hormonal balance ☐ Relief from neck and back pain ☐ Support with sleep

Other - Please give details:

Aromatherapy: Are you allergic to/have any intolerances to any essential, plant or nut oil?

May we use them on you as part of your session? ☐ Yes ☐ No

Please give details:

Are you generally okay with physical adjustments and touch during your session? ☐ Yes ☐ No

Please list any food requirements/intolerances/allergies (only applicable for half and full day workshops)

Please answer 'yes' or 'no' in the box if any of these relate (or in the past, have related) to you:

SYMPTOM / CONDITION	YES	NO	DETAILS		
Adrenal Fatigue/Depletion or Burn out					
High/Low Blood Pressure			Medication?	Dizziness?	
Back injuries			Current?	Past?	Painful?
Neck/Shoulder injuries			Current?	Past?	Painful?
Hip or knee injuries			Current?	Past?	Painful?
General Joint Pain					
Fertility Concerns					
Hormonal Imbalance					
Menopausal symptoms					
Cardiac/respiratory conditions			Medication?		
Anxiety			High	Medium	Low
Depression			Medication?		
Underactive/Overactive thyroid/ thyroid disease			Medication?		
Difficulty hearing			Hearing Aid?	Tinnitus?	Inner ear?
Level of stress in my life right now			High	Medium	Low
Other conditions or medication or details:					

I would like to receive mailings from Sharon Kempthorne Restorative Therapeutics to advise me on sessions/workshops/upcoming promotions.

☐ Yes
☐ No

AGREEMENT:

☐ I have read, understood and agree to the terms and conditions in this link here>

In addition, I, ______________________________
understand that the instructions given throughout the session/workshop are only intended as guidance. It is therefore my responsibility to adjust my practice according to my limitations to ensure no personal injury occurs and, to inform my teacher before sessions of any recent change to my physical/emotional or mental condition. I agree to release Sharon Kempthorne Restorative Therapeutics of any responsibility for any injury sustained. I will take full responsibility for myself during my session/workshop. The answers I have given in my electronic submission of this form are a true and accurate record of my registration details and health status, as at the date of submission.

Signed: ______________________________ Date: ____________________

Thank you for taking the time to complete this registration.
This information helps us to support you in your practice.