

2011-2013 Ayurvedic Medicine Certificate Program Registration Forms

Please:

- 1) Fill out and sign all forms.
- 2) Return the GOLD FORMS to:

**The Awareness Center
2801 E. Foothill Blvd.
Pasadena, CA 91107**

- 3) Return the remaining forms with your TUITION to:

**The American University of Complementary Medicine
415 North Camden Drive
Beverly Hills, CA 90210, Suite 203
310-550-7445
www.aucm.org**

Please note that the A.U.C.M is solely responsible
for registration, tuition and course curriculum.

- 4) Keep copies of all forms for your personal records.

If you have questions please contact:

Ravijot Kaur

626.796.1567 ravijot@awarenesscenteryoga.org

www.awarenesscenteryoga.org



**2011-2013
Ayurvedic Medicine Certificate Program
Statement of Responsibility**

I, the undersigned, understand that The Awareness Center is a satellite location for The American University of Complementary Medicine and is providing the training location for the Ayurvedic Medicine Certificate Program from October 2011 to September 2013.

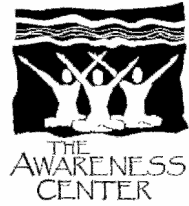
The American University of Complementary Medicine is solely responsible for registration, tuition, course curriculum, instructors and liability.

I hereby release The Awareness Center, its employees, sub-contractors, lessees, representatives, and agents from any and all responsibility.

I have read and fully understand and agree to the foregoing release.

Signature

Date



**2011-2013
Ayurvedic Medicine Certificate Program
Setting Your Intentions**

Name: _____

Please set your intentions for personal transformation.

Spiritual:

Mental / Emotional:

Health / Fitness:

Material/Financial:



**2011-2013
Ayurvedic Medicine Certificate Program
Emergency Contact Information**

Name of Trainee: _____

Name of Emergency Contact 1: _____

Relationship to Trainee: _____ Home # _____

Cell # _____

Name of Emergency Contact 2: _____

Relationship to Trainee: _____ Home # _____

Cell # _____

Nearest Relative: _____

Relationship to Trainee: _____ Home # _____

Cell # _____

Address: _____

City: _____ State: _____ Zip: _____



**2011-2013
Ayurvedic Medicine Certificate Program
Health History Form**

Name _____

In order to provide a safe and effective program it is important that you complete the following Health History. It is crucial that you answer all the questions honestly and to the best of your ability. Please be advised that all the information is kept strictly confidential.

Circle the appropriate response. Read all questions thoroughly.

- | | | |
|---|-----|----|
| 1. Has your doctor ever told you that you have heart problems? | YES | NO |
| 2. Has your doctor ever told you that you have high blood pressure? | YES | NO |
| 3. Have you ever had a stroke or heart attack? | YES | NO |
| 4. Have you ever had pain in your chest? | YES | NO |
| 5. Do you ever feel faint or have dizzy spells? | YES | NO |
| 6. Have you had surgery in the last six months? | YES | NO |

If yes, please explain _____

Circle the appropriate conditions

DIABETES	EPILEPSY	BLOOD PRESSURE	ASTHMA
ARTHRITIS	HEART	HIGH CHOLESTEROL	SEIZURES

Have you injured or have pain in the following areas? Circle the appropriate areas.

NECK	UPPER BACK	SHOULDERS	ELBOWS
KNEES	LOWER BACK	HIPS	WRISTS

If yes, please explain _____

Health History Continued

Are you currently taking any medications? YES NO

If you circled "yes" please list medications, and for what condition.

1. _____

2. _____

3. _____

Are you currently undergoing treatment from any of the following?

Physiotherapist _____ Chiropractor _____ Massage Therapist _____ M.D. _____

Psychotherapist _____ Counselor _____

If yes, why? _____

What is your current exercise level?

None _____ Once per week _____ 2-3 times per week _____ 4-5 times per week _____

What type of exercise? _____

How would you rate your level of stress on a daily basis?

Low _____ Moderate _____ High _____

Estimate how many hours of sleep you get each night. _____

Are there any other reasons/conditions that may affect or limit your participation in the program?

You are encouraged to abstain from alcohol, tobacco and drug use during the program.

Signature _____ Date _____

