YOGA HEALTH QUESTIONNAIRE

Name:	
e-mail :	
Mobile:	
Address:	

All information is strictly confidential

Age Group	Under 16	17-34	35-44	45-65	65+

Have you done Yoga before?	Yes/No
If yes, what type(s) and for how long?	
What is your main reason for wanting to do yoga?	

Which aspects of Yoga most interest you? Please tick as many as you wish:

☐ Physical postures (asanas)	☐ Breathwork (pranayama)
☐ Relaxation	☐ Meditation
☐ Chanting & Healing	Other aspects (please say which):

Do any of these health conditions apply to you?		**If yes, please give details:**
High blood pressure	Yes/No	
Low blood pressure/fainting	Yes/No	
Arthritis	Yes/No	
Diabetes	Yes/No	
Epilepsy	Yes/No	
Heart Problems	Yes/No	
Asthma	Yes/No	
Depression/Anxiety	Yes/No	
Detached retina/other eye problems	Yes/No	
Recent fractures/sprains	Yes/No	
Recent operations	Yes/No	
Back problems	Yes/No	
Knee problems	Yes/No	
Neck problems	Yes/No	
Recent pregnancies	Yes/No	
Are you pregnant?	Yes/No	
Do you have any other conditions which affect your mobility or are likely to cause you concern when doing Yoga?	Yes/No	

	Please Tick
I take full responsibility for my health during the yoga classes, including any injuries.	
I will inform my yoga teacher of any medical changes.	
I'm happy to be contacted via email about The Yoga Social classes and events	
Signed	**Date:**

Thank you very much for taking the time to fill out this form. Namaste.

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