HEALTH QUESTIONARE FOR YOGA

Name …………………………………………………………………. Telephone ……………………………………….

Email (please print carefully) …………………………………………………………...

Age group 17-34 35-44 45-64 65+

Have you done yoga before YES/NO?

If YES what type and for how long ………………………………………………………………...

What is your main reason for wanting to do yoga?

|  |  |  |
| --- | --- | --- |
| **Do any of these health conditions apply to you** | **Yes/no** | **If yes give details** |
| High blood pressure |  |  |
| Low blood pressure/fainting |  |  |
| Arthritis |  |  |
| Diabetes |  |  |
| Heart problems |  |  |
| Asthma |  |  |
| Detached retina/eye problems |  |  |
| Depression |  |  |
| Recent fracture/sprains |  |  |
| Recent operations |  |  |
| Back problems |  |  |
| Knee problems |  |  |
| Neck problems |  |  |
| Recent pregnancies |  |  |
| Pregnant now |  |  |
| Do you have any other conditions that are likely to cause you concern doing yoga? | Yes/No |
| If yes give details |  |
| How did you hear about this class? |  |

**I will take full responsibility for my health during the yoga classes, including any injuries. Please listen carefully and with care to your own body**

Signed………………………………………………………………………