YOGA HEALTH QUESTIONNAIRE

Name:

D.O.B

Email address:

Address & Contact number:

Next of Kin or contact details in case of emergency:

Previous Yoga experience & Yoga Level:

Exercise sessions or hours per week:

Would you consider yourself : Fit: Unfit:

Do you suffer any health problems or under treatment with a Doctors/ Physiotherapy/ Osteopathy / Chiropractic/ Herbalist Supervision:

Are you taking medication or Herbal remedies and if so what for:

Have you had any major accidents or injuries in the past 12 years. If so does this affect your well being:

Have you had any operation in the past 5 years and if so what was it for:

Do you currently suffer with any of the below conditions:

Insomnia Anxiety Depression Mental – Illness Eating disorders

Hormonal condition Asthma Diabetes Allergies Heart conditions

High/ Low Blood Pressure Back or Neck pain Cancer M.E. H.I.V

Epilepsy Migraines Glaucoma Dizzy spells Arthritis

Are you pregnant: How many weeks:

Dietary requirements:

(Vegan / Vegetarian/ Lactose , Dairy, Wheat, Gluten or Nut Allergies)

DATE:

SIGNATURE: