

# Yoga Health Questionnaire

Please complete the following form. All information is necessary for your own safety, is treated with the strictest of confidence and never shared with third parties.

First name: \_\_\_\_\_

Surname: \_\_\_\_\_

Email: \_\_\_\_\_

Telephone: \_\_\_\_\_

## In case of an emergency:

Next of KIN: \_\_\_\_\_

Telephone: \_\_\_\_\_

## Do you have, or have you had, any of the following health conditions?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> High blood pressure       | <input type="checkbox"/> Low blood pressure                               | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> High stress/anxiety       | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Asthma        |
| <input type="checkbox"/> Headaches/migraine        | <input type="checkbox"/> Joint/bone problems e.g. arthritis, osteoporosis |  |
| <input type="checkbox"/> Other, please state _____ |   |  |

If you have a history of health problems of any kind or if you are currently on any medication please elaborate.

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## Any previous experience of Yoga?

Years: \_\_\_\_\_ Style: \_\_\_\_\_ Other sports/interests? \_\_\_\_\_

## Declaration:

- I can confirm that I am fit and healthy to start yoga
- I consent to my email address being used to keep me informed about classes

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



If you are in any doubt please confirm with your Doctor and always tell your teacher of any changes in your health.