Yoga Health Questionnaire

Please answer the questions below so that I can be aware of any potential issues - and maybe help!

Name	
Telephone Number	
Emergency Contact Name	
Emergency Contact Number	

Please tick if any of the following apply to you:	yes	no
High blood pressure		
Low Blood pressure		
Heart problems (angina, irregular beat, heart attack)		
Breathing Problems (asthma, COPD)		
Hearing or sight problems		
Fainting/ dizziness/ falls (within the last year)		
Surgery (within the past 3 years)		
Diabetes		
Joint conditions eg arthritis		
Joint replacements		
Epilepsy		
Pregnant or recently given birth		
Taking medication or prescribed drugs		

If you have ticked any boxes, or if there is anything else that might be a concern, please provide any other details that could be relevant when practicing Yoga on the back to this sheet. You may also wish to consult your GP.

Please turn over!

Further information

I have read this form and answered all questions accurately. I understand that I am responsible for monitoring myself and take full responsibility of my own actions. I will inform the instructor if any symptoms or changes occur.

Signature: Date:

I have read the form and taken note.

Yoga Teacher Date: