

Confidential Information Request

Name:

Address:

Email:

Tel Home:

Mobile:

Date of birth:

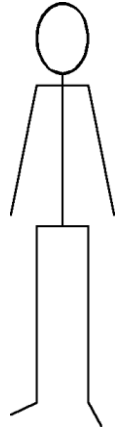
Occupation:

1. Please circle any area where you have pain or there is a problem. Is this a recent development or a chronic problem?

2. Please describe any movement that might cause problems for you (draw stick figures if possible).

3. Are you pregnant?

4. Please indicate any health issues below and whether they are old or current.



Health Issue	O	C	Health Issue	O	C	Health Issue	O	C
Anxiety			Depression			Hay fever		
Arthritis			Diabetes			Heart problems		
Asthma			Digestive problems			Insomnia		
Back pain low/mid/neck			Eliminative problems			Menstrual difficulties		
Blood pressure low/high			Eye problems			Migraine		
Cancer			Disc problems			Pre-menstrual symptoms		
Circulation problems			Dizziness			Respiratory problems		

5. Please detail any recent injuries, illnesses, operations or problems.

6. Are you receiving treatment from a doctor? If so, for what condition? Please give details of any medication.

7. Do you have any difficulties which could be exacerbated by yoga practice?

8. How did you hear about this class?

9. Have you done yoga before? If so, give details of the type or approach.

10. Apart from yoga, are you involved in any other disciplines, sports or activities?

11. What outcomes would you like to see from your yoga practice?