

STUDENT HEALTH QUESTIONNAIRE

All information given will be treated in the strictest confidence and stored in accordance with Data Protection legislation.

Name:

Address:

D.O.B.: **Mobile:**

E-mail:

Emergency contact name and tel. no:

Have you attended a yoga class before?

If yes, how long have you practiced yoga?

If yes, what style of yoga have you practiced? (if known)

How did you hear about this class?

Do you participate in any other physical activity, e.g. gym work, jogging, swimming, aerobics, badminton, cycling, walking or other?
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How regularly do you do this?

What do you hope to achieve from this yoga class?
e.g. strength/flexibility, health/fitness, better posture, stress relief, mental & emotional well being

The following information is required to ensure your safety. Whilst yoga may be practiced safely by the majority of people, there are certain conditions which require special attention. If you are unsure please consult your GP before commencing class. Please tick the boxes below if you have any of the following medical conditions.

These conditions require specific modifications to your yoga practice. If yes, please give details.

- abdominal disorder or recent surgery
- arthritis (osteo or rheumatoid)
- back pain (if known cause please state)
- knee problems
- hip problems
- shoulder or neck problems
- heart disorders
- high blood pressure
- low blood pressure

- asthma
- diabetes
- auto-immune disorder (e.g. M.E. M.S. Lupus etc)
- epilepsy
- anxiety/depression
- sensory disorder affecting eyes or ears
- balance affecting disorder
- other (to be discussed with tutor)

Are you /could you be, pregnant, or have you given birth in the last six weeks? Yes/No

Do you have any old injuries that still trouble you? Or any other medical conditions not covered above that might be adversely affected by yoga practice? Yes/No
If yes, please provide details.

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Have you had any recent operations (in the last two years)? Yes/No
If yes, please advise what the operation was.

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DECLARATION

Please tick this box if you DO NOT wish to declare medical information

I confirm the above information is correct. I understand that it is my responsibility to:-

- Check with my doctor if I have any difficulties or concerns about my ability to participate in the yoga class.
- Advise the yoga tutor of any change in my medical information
- Follow the advice given by my doctor and/or yoga teacher.

Name: (please print).....

Signed:..... **Date:**.....

- Please tick if you DO NOT wish to be contacted regarding any future yoga classes, workshops or yoga retreats that might be of interest to you.
- Please tick if you DO NOT wish your details to be passed to a yoga teacher who may be covering the class in my absence.
- Please tick if you DO NOT wish for any photographs/videos to be used for any promotional purposes.