Health Questionnaire

Name	Date of Birth

Contact Details:
Email
You will be added to our mailing list, where you will receive news about upcoming classes, workshops, retreats and special offers. Please tick this box if you would not like to be added to the mailing list. ☐

Health Information

Have you done yoga before? YES/NO If YES what type and how long ago?

Do you have any of these health conditions? (If YES please give details in the box below.)

High/Low Blood Pressure	☐	Epilepsy	☐	IBS	☐
Heart Problems	☐	Migraine	☐	Asthma	☐
Osteoporosis	☐	Arthritis	☐	Diabetes	☐
Depression	☐	Eye Problems	☐	Back Problems	☐
Neck Problems	☐	Knee Problems	☐	Recent surgery	☐

Please give details of health conditions which may cause you concern during yoga:

Emergency contact details:
Name Phone

I have read and understood the questions above and have supplied the correct information to the best of my knowledge. I take responsibility for myself in the yoga class and will inform my teacher of any medical changes.

Signed ______________________ Date ______________________