

Medical Questionnaire

ALL INFORMATION GIVEN WILL BE TREATED CONFIDENTIALLY

Do you have any of the following conditions or symptoms? If so, please give details.

1	Heart condition	Y / N
2	High or low blood pressure	Y / N
3	Dizziness or fainting	Y / N
4	Depression or anxiety	Y / N
5	Joint or muscle problems, including: bad back, knee, shoulder, neck etc	Y / N
6	Chronic conditions such as arthritis, MS, ME etc	Y / N
7	Asthma or bronchitis	Y / N
8	Recent or current pregnancy	Y / N

Please give further details including approximate date condition identified, whether the condition is subject to ongoing treatment and if so, how.

Is there any other information that may be relevant?

Do you have any previous experience of yoga and what are you hoping to get from this course?

- I confirm that I have read and understood both the student information sheet and the medical questionnaire and provided all relevant information.
- I understand that if I become ill or suffer an injury either before or during a class it is my obligation to tell the teacher immediately.

Name

Address

Telephone

Email

Signature

