Registration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Client Health Questionnaire**

Title:

First Name:

Surname:

Date of Birth:

Address/ Town / County:

Postcode:

Contact Telephone:

Email Address:

Occupation:

**About You**

Have you practiced yoga before? Y/N

If yes, please give more details:

Do any of these health conditions apply to you (if yes, please give details):

High blood pressure Y/N

Low blood pressure/fainting Y/N

Arthritis Y/N

Diabetes Y/N

Epilepsy Y/N

Heart problems Y/N

Asthma Y/N

Depression Y/N

Detached retina/other eye problems Y/N

Recent fractures/sprains Y/N

Recent operations Y/N

Back problems Y/N

Knee problems Y/N

Neck problems Y/N

Recent pregnancies Y/N

Are you pregnant? Y/N

Any allergies? Y/N

If yes, please provide more details:

Do you take any regular medication? Y/N

If yes, please provide more details:

Do you smoke? Y/N

If yes, please provide more details:

Have you had any injuries either in the past or present? Y/N

If yes, please provide more details:

Which elements of Yoga most interest you? Please tick as many as you wish:

□ Physical yoga postures (asanas)

□ Breathing techniques (pranayama)

□ Relaxation

□ Meditation

**Administration**

All information provided is confidential and will not be passed onto third parties.

I consent to you storing medical records, which may include details concerning my medication, treatment and other issues affecting my health conditions, in accordance with the General Data Protection Regulation (GDPR).

For the purposes of future appointments and administration, I consent to being contacted by telephone, email, post or other (please state) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have read and understood the above information and agree to give my explicit consent. I take full responsibility for my health during the yoga classes, including any injuries. I will inform my yoga teacher of any medical changes.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name (PRINT): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_