**Health questionnaire for new students attending Yoga with Becky Richards**

All information is strictly confidential and will be kept on paper only

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| Name |
| e-mail: please print carefully |
| Tel: home | mobile |
| Address: |  |  |
| Next of kin Name: Mobile phone no. |

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| --- | --- | --- | --- | --- | --- |
| Age Group: | Under 16 | 17-34 | 35-55 | 55-65 | 65+ |

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| Have you done Yoga before? |
| If yes, what type(s) and for how long? |
| What is your main reason for wanting to do yoga? |

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

# Physical postures (asanas) □ Breathwork (pranayama)

* Relaxation □ Meditation

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| Other aspects of interest?  |

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| **Do any of these health conditions apply to you?** | If yes, please give details: |
| High blood pressure | Yes/No |  |
| Low blood pressure/fainting | Yes/No |  |
| Arthritis | Yes/No |  |
| Diabetes | Yes/No |  |
| Epilepsy | Yes/No |  |
| Heart problems | Yes/No |  |
| Asthma | Yes/No |  |
| Depression | Yes/No |  |
| Detached retina/glaucoma/other eye problems | Yes/No |  |
| Recent fractures/sprains | Yes/No |  |
| Recent operations | Yes/No |  |
| Back problems | Yes/No |  |
| Knee problems | Yes/No |  |
| Neck problems | Yes/No |  |
| Recent pregnancies | Yes/No |  |
| Are you pregnant? | Yes/No |  |

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| Do you have any other conditions that affect your mobility or are likely to cause you concern when doing Yoga? | Yes/No |
| If Yes, give details: |
| How did you first hear about this class? |

In order to comply with the General Data Protection Regulations, I must check if you are happy for me to retain your contact details, and to email you information I think will be useful to you, including training and events, and relevant updates. I only hold information when it is necessary for me to carry out my work, and when you have given me permission to do so. Please indicate if you agree to this **Yes / No**

I take full responsibility for my health during the yoga classes, including any injuries.

I will inform my yoga teacher of any medical changes.

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| **Signed** | **Date** |