MKH
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Please complete the following questionnaire. It will help determine appropriate and safe yoga practices for you. *This information is only for your instructor's use and will be held in the strictest of confidence.* Thank you for taking the time to complete this form.

<u>Part A: Client Personal History</u>

Date:_______________________

Name:____

Age:______

Mailing Address:____

Phone(s):____

Email:____

Emergency Notification:

Name:____

Relationship:____

Emergency Contact phone(s):____________________________________

How would you describe your overall health? ___________________________________

Do you have any joint pain? If so, where? ______________________________________

____

Have you found ways to provide relief? If so, how?__________________________

____

Do you have any muscle pain or tension? If so, where?_____________________________

____

Have you found ways to provide relief? If so, how?____________________________________

____

Are you satisfied with your posture?____

What kind of work do you do? (For example, Do you mostly sit? Stand? Do you travel?)______

____

Are you comfortable at work?____

Are you comfortable when working on hobbies?____

What do you do for exercise?____

____

What do you do for relaxation and stress reduction?____

____

Do you have specific goals to address with yoga?____

____

Part B: Client Health History

Current Health Status:

Are you currently seeing a health care provider? If so, what for?______________________________

____

Are you taking prescription or non-prescription medications? If so, what are they for?

____

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	No	yes, less than a year	yes, more than a year
High blood pressure			
Hypoglycemia			
Seizures			
Diabetes			
Anemia			
Asthma			
Other breathing problems			
Smoking			
Dizziness, vertigo or loss of balance			
Neurological diseases			
Headaches			
Vision difficulties			
Glaucoma			
Heart problems			
Pacemaker			
High Blood Pressure			
Low Blood Pressure			
Blood thinners			
Chest pain			
Shortness of breath			
Hearing difficulty			
Hernia/rupture			
Rheumatoid arthritis			
Osteoarthritis			
Osteoporosis			
Osteopenia			
Unexplained falls or fractures			
Broken bones			
Joint Problems or unstable/ “trick” joint(s)			
Joint dislocation			
Joint swelling			
Metal implants/artificial joints			

Back problems/pinched nerves or disc problems			
Neck problems/pinched nerves or disc problems			
Traumatic auto accidents			
Cancer			
Allergies			
Night sweats			
Bladder or bowel control problems			
Major surgeries			
Skin Abnormalities			
Chronic Fatigue			
Fibromyalgia			
Special Diet Guidelines			
Depression			
Bipolar Disorder			
Panic/Anxiety Disorder			

Other chronic condition:-
____

____
____

____

Are you pregnant? Yes No

Please briefly explain any of the health problems noted above:-
____

____

____