

HEALTH INFORMATION FORM

*All information will be kept confidential – For instructor use only
Complete this form only once, but please inform your yoga instructor if there are changes in your health that might affect your yoga practice.*

Please indicate which of the following best describes your current state of health:

_____ Great _____ Good _____ Average _____ Poor

Are you taking any long-term prescription or over-the-counter medication, which might affect your yoga practices? Y N

If yes, please list the medication and the reason you are taking it:

Please check any of the following health issues that affect you or may limit you in participating in a yoga class & please be sure you discuss these issues with the Yoga Instructor:

- | | |
|---|--|
| <input type="checkbox"/> Uncontrolled High Blood Pressure | <input type="checkbox"/> Back Problems or Injury |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Knee Problems or Injury |
| <input type="checkbox"/> Detached Retina | <input type="checkbox"/> Shoulder Problems or Injury |
| <input type="checkbox"/> Neck Problems or Injury | <input type="checkbox"/> Hip Problems or Injury |
| <input type="checkbox"/> Sciatic Nerve Issues | <input type="checkbox"/> Current Pregnancy |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

Please describe any other medical conditions, which may affect your yoga practice: _____

Please describe any other medical conditions: _____

Do you have any questions or concerns regarding participation in yoga class:

Name: _____

Address: _____

Phone: Home _____ Cell _____ Work _____

E-mail: _____