Medical Questionnaire

Print Clearly:

Name: ____

Cell Number: ____

Date of Birth: ___________________________ Age: ___________ Gender: _____________________

Address: ____

What types of exercise or physical activity do you participate in and with what frequency?

____

Do you have a diagnosis by a physician? If yes, please describe?

____

Have you had any injuries or surgeries in the last 5 years? If yes, please describe:

____

Are you taking any medication? If yes, please describe:

____

Do you have any medical condition(s) that may affect your participation in class? Including but not limited to: blood pressure issues; heart problems; spine injury; joint problems; neck, back, shoulder, hip, or knee problems)? If yes, please describe:

____

Is there any time of day or night that you experience pain or discomfort?

Time of Day: _________________________ Location: _______________________________________

Please rate/explain the severity of above listed pain/discomfort on a scale of 1-5: ____________

What makes you feel better? ____

What makes the pain worse? ____

Emergency Contact Name: _______________________________ Phone: ______________________

The above information is complete and accurate to the best of my knowledge and I have consulted with a physician regarding my participation in the yoga classes. I agree to inform my teacher of any of this information changes in the future.

Signature: ____ Date: ________________