HEALTH HISTORY

Name: _____

Home phone: _____ Cell phone: _____

Email: _____

Address: _____

Emergency contact: _____ Phone number: _____

What is your present state of health?

_____

Are you under the care of a physician and/or on medications? _____

Describe your current exercise program._____

_____

What experience do you have in yoga?

_____

What do you hope to accomplish by practicing yoga?

_____

_____

Please check any conditions you currently have.	YES	NO
1. Blood pressure problems	___	___
2. History of heart problems, chest pain or stroke	___	___
3. Pregnancy	___	___
4. Difficulty with exercise	___	___
5. Advice from a physician not to exercise	___	___
6. Surgery within past year	___	___
7. Muscle, joint, neck or back issues	___	___
8. History of lung or breathing problems	___	___
9. Detached retina or glaucoma	___	___
10. Other (describe below)		

If you checked “yes” please comment below.

_____

_____