**Health and lifestyle Questionnaire for Yoga Therapy**

*The information provided here will be kept strictly confidential.*

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| --- | --- |
| **Name** |  |
| **Date of Birth** |  |
| **Address** |  |
| **Telephone** |   |
| **Email Address** |  |
| **Occupation** |  |
| **Emergency Contact** |  |

**Personal Information**

|  |  |
| --- | --- |
| **What are you interested in achieving from yoga sessions?** |  |
| **Describe your current levels of exercise** |  |
| **What makes you feel good?** |  |
| **What are your interests / hobbies?** |  |
| **Have you seen a doctor for any health issues?** |  |
| **Have you seen any other health practitioners (**i.e. Physiotherapist, Acupuncturist, Chiropractor, Osteopath, Herbalist)? |  |
| **Are you pregnant?** |  |
| **Are you currently taking any medication?** |  |
| **Are you currently taking any herbs, supplements, or other remedies?**  |  |
| **Please include anything else that you feel is relevant** |  |

**Current Health**

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| **Height** |  | **Weight** |  |
| **Energy level** good / poor / moderate / erratic |  | **Appetite** good / moderate / poor / erratic |  |
| **Sleep onset** fast / takes time / erratic |  | **Sleep quality** good / moderate / poor /erratic |  |
| **Digestion**normal /heartburn / indigestion / reflux / bloating / etc. |  | **Bowels** regular / loose / irritable / constipated / erratic |  |
| **Menstruation**normal / painful / irregular / absent / menopause / HRT |  | **Kidneys / Bladder** normal / urination problems / cystitis  |  |
| **Breathing problems** (asthma, COPD etc.) |  | **Heart / Circulation** high blood pressure / low BP / arrhythmia / angina |  |
| **Muscle / joint pain / stiffness** (describe) |  | **Headaches** (Frequency? Migraine / tension?) |  |
| **Problems with eyes / ears / nose / mouth?** |  | **Skin problems?** |  |
| **Typical diet**allergies / exclusions |  | **Mealtimes** regular / erratic / late in the evening |  |
| **Do you drink alcohol?** |  | **Do you smoke?** |  |
| **Do you drink caffeine?**  |  | **How much water do you consume daily?** |  |
| **Nervous system** stroke / fainting / dizziness / pins and needles / numbness |  | **Emotions/** **moods** stress/ anxiety / depression / irritable / other |  |

**Medical and Family History**

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| --- | --- |
| **Please list any previous or current events** |  |
| **Please list any chronic family health conditions** |  |

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| *The above information is correct and I am willing to provide further information in follow-up sessions.* *I understand that I am taking part in a yoga programme, and I am responsible for my own well-being. I will seek support from the yoga therapist/yoga teacher when needed and stop doing any part of the programme if it causes pain/discomfort, exceeds my personal limitations or makes me feel unwell.* |
| **Name** |  |
| **Signature** |  |
| **Date** |  |