

YOUR YOGAFIX FACTS

Please complete and return – thank you

Your contact details

Name:		Email:	
Tel hm / wk:		Address:	
Tel mb:			
Birthday:			

Your yoga lifestyle

Have you practiced yoga before?	How long have you practiced yoga?
What do you enjoy about yoga?	

Your wellbeing

Please tick below if you have, or have ever had any of the following:

- | | | | |
|---|--------------------------|-------------------------------|--------------------------|
| Angina | <input type="checkbox"/> | Asthma | <input type="checkbox"/> |
| Heart condition | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> |
| High blood pressure | <input type="checkbox"/> | Varicose veins | <input type="checkbox"/> |
| Low blood pressure | <input type="checkbox"/> | Eye complaint (e.g. glaucoma) | <input type="checkbox"/> |
| Epilepsy | <input type="checkbox"/> | Migraine | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Hernia | <input type="checkbox"/> |
| Back, neck or joint problems (please specify) | <input type="checkbox"/> | Hiatus hernia | <input type="checkbox"/> |

If you have recently had a major illness, injury or surgery please specify below:

If you are currently taking medication or having complementary treatment please specify below:

If necessary, please check with your doctor before attending yoga classes.
If you are pregnant, or become pregnant please let me know.

If you would like to receive more information about yoga please tick here

Please sign:

Date: