Health Questionnaire

Date (dd/mm/yy) / /

I am interested in yoga therapy for the following condition(s)

Name

Marital status

Address

Home tel Work tel

Mobile tel E-mail

Where have you heard about me?

DOB (dd/mm/yy) / /

Height *cm* Weight *kg*

Sex male female

if female state number of children DOB of youngest child / /

Once we start working with people we like to notify their GP. If you have no objections to this please give your Doctor's name and address

Present occupation

Past occupation(s)

Are you currently, or have you ever been off work because of this condition? *Y / N*

if yes, for how long?

Have you ever attended a hospital or clinic for this condition? *Y / N*

if yes, indicate whether you have had x-rays or scans and give details of any medical diagnosis, treatments or surgery you have had

Please give details of any other major illnesses, accidents or operations you have had (including dates)

Have you been to complementary/alternative practitioners for your condition? *Y / N*

if yes, please give details

Have you ever practiced yoga before? *Y / N*

if yes, please give details

if yes, how did it affect your condition?

Do you smoke? *Y / N*

How often do you drink alcohol?

- ☐ 1-3 times per week
- ☐ 1-3 times per month
- ☐ 1-6 times per year
- ☐ every day
- ☐ never

What forms of exercise do you take, for how long and how often?

Please tick any of the following that you currently suffer from or have suffered from in the past

- ☐ arthritis
- ☐ back, shoulder or neck pain
- ☐ other back problems *(e.g. Scoliosis)*
- ☐ Rheumatism
- ☐ damaged joints or muscles in arms or legs

- ☐ high blood pressure *(excluding during pregnancy)*
- ☐ varicose veins
- ☐ heart disorders
- ☐ other circulatory disorders

- ☐ asthma
- ☐ nasal allergy/hay fever
- ☐ other breathing problem (please state)
- ☐ sinusitis
- ☐ chronic bronchitis or emphysema

- ☐ stomach or duodenal ulcers
- ☐ indigestion
- ☐ diarrhoea
- ☐ other digestive disorders (including bowel, liver, pancreas and gall bladder disorders)
- ☐ constipation
- ☐ hiatus hernia
- ☐ inguinal hernia

- ☐ kidney problems
- ☐ other disorders of genito-urinary tract *(including infertility, prostalitis, cystitis)*

- ☐ pre-menstrual tension
- ☐ other menstrual problems
- ☐ menopausal problems
- ☐ pregnancy or childbirth problems *(including high blood pressure, miscarriage, etc.)*

- ☐ diabetes
- ☐ other headaches
- ☐ migraine
- ☐ cancer

- [ ] insomnia
- [ ] excessive depression
- [ ] epilepsy
- [ ] excessive fatigue
- [ ] excessive anxiety
- [ ] mental disorders

Please tick any of the following medicines you took (even once) over the last year.

- [ ] laxatives
- [ ] antibiotics
- [ ] anti-inflammatories
- [ ] sleeping pills
- [ ] other medicines *(please state)*
- [ ] indigestion tablets
- [ ] pain killers *(including aspirin)*
- [ ] high blood pressure drugs
- [ ] tranquilisers
- [ ] anti-depressants

Please give details of any family (parents, sisters, brothers, children) illness of significance
including asthma, diabetes, rheumatoid & osteo-arthritis, heart disease, stroke, cancer, back pain

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