



Living Your Yoga

MIXED ABILITY HEALTH QUESTIONNAIRE

Name:

Date of birth:

Address:

Mobile number:

Email address:

Emergency contact name:

Emergency contact number:

Doctors name:

Surgery telephone number:

Surgery address:

Health conditions/details (including pregnancies/operations/injuries):

Are you taking medication? If so, please provide details:

Food/general allergies:

Yoga experience:

What do you hope to gain from your yoga practice?

Are you happy to receive hands-on assistance/adjustment?

Yes

No

I declare that the information I have given here is correct and as far as I am aware I can participate in yoga classes/1:1 sessions.

I understand that it is my responsibility to inform the teacher of any health situation/problems.

I understand that my body is my responsibility and that should I be uncomfortable or in pain during an exercise I need to talk to the yoga practitioner at the time so that suitable variations can be provided.

I understand that this form is strictly confidential and is solely for the use of the yoga practitioner to help provide a safe environment within classes and 1:1 sessions.

Signed:

Print name:

Date: