Living
Your Yoga

WELL-WOMAN HEALTH QUESTIONNAIRE

Name:
Date of birth:
Address:

Mobile number:
Email address:
Emergency contact name:
Emergency contact number:

Doctors name:
Surgery telephone number:
Surgery address:

Menopause symptoms & medication or practices used to help with symptoms:

Other health conditions/details (including pregnancies/operations/injuries):

Living Your Yoga | 39 Watling Road | Kenilworth. CV8 2HS
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Are you taking any other medication? If so, please provide details:

Food/general allergies?

Yoga experience:

What do you hope to gain from your well-woman yoga practice?

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:

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