MEDICAL HISTORY FOR YOGA THERAPY

Name: _____ Birthdate: _____

Address: _____PC:_____

Phone: _____ E-mail : _____

EMERGENCY CONTACT: _____

Occupation: _____ STRESS LEVEL (1-10) _____

My main health concern is _____

This condition began _____

It is aggravated by _____

Major surgery/accidents _____

My energy level is _____

To relax, I _____

My regular exercise includes _____

Previous yoga experience: _____

How do I expect to benefit from yoga? _____

THE FOLLOWING APPLY TO ME:

- ☐ Cancer
- ☐ Active Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Heart Condition
- ☐ Circulatory Disorder
- ☐ Varicose Veins
- ☐ Pregnancy-due date-
- ☐ Asthma
- ☐ Kidney/urinary problems
- ☐ Epilepsy
- ☐ High/Low Blood Pressure
- ☐ Diabetes
- ☐ Headaches
- ☐ Allergies
- ☐ PMS
- ☐ Digestive Problems
- ☐ Surgical Implants
- ☐ Medications_____
- _____
- ☐ Homeopathic Remedy
- ☐ Chiropractic Treatment
- ☐ Irregular Sleeping Patterns

☐ Unexplained symptoms: dizziness, nausea anxiety or_____

☐ Other conditions_____

I, the undersigned, am attending yoga therapy classes at ***Centerpoint Yoga Therapy Studio*** *based on my own decision and acknowledgement of the inherent risks associated with any physical exercise including yoga. I understand that the classes are gentle and that the instructor will individualize the teaching as much as possible. I agree to be responsible for my own safety and well-being and that I, my heirs, executors, and administrators will hold no one (including Leila Stuart) responsible for any injury, loss or damage, whether physical or mental, arising out of attendance of these yoga classes.*

Date: _____ Location _____ Signature: _____