

# PATHWORKS YOGA

## Health Information Form

First name you prefer: \_\_\_\_\_ Last name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Emergency Contact (name, relationship, phone number)

\_\_\_\_\_

Recreational physical activity: \_\_\_\_\_

Previous yoga or fitness experience: \_\_\_\_\_

Any experience with meditation: \_\_\_\_\_

What do you hope yoga will help with (circle as many that apply):

Strength   Flexibility   Energy   Coordination   Stress Reduction   Focus   ALL

How did you learn about Pathworks Yoga? Circle one:

Kobukai JJ instructor or student   /   Email   /   Online Directory   /

Flyer   /   Pathworks website   OTHER \_\_\_\_\_

### **THE FOLLOWING HEALTH INFORMATION ASSISTS US IN SERVING YOU.**

**All information is confidential and will only be used by the instructor to assist you in class.**

PLEASE NOTE: THIS YOGA CLASS IS NOT SUITABLE TO PREGNANT WOMEN. If you are pregnant participation in this class may cause miscarriage. There are separate and specific requirements for a yoga practice intended for pregnant women. At some point in the future we may offer prenatal classes, so please check back with us at a later date.

Major surgery, accidents or injuries and how long ago?

\_\_\_\_\_

\_\_\_\_\_

Do you have any challenges or difficulty:

sleeping   walking   sitting   sitting on the floor   standing   lying down   bending

Are you taking the following medications regularly:

High blood pressure      Anti-inflammatories      Pain killers/muscle relaxers

Check any of these conditions which are applicable to you:

- Allergies
- Arthritis    Circle one: Osteo / Rheumatoid
- Asthma
- Cancer
- Inflammatory Bowel Disease  
Diagnosis? \_\_\_\_\_
- Diabetes
- Depression (Pathworks Yoga takes the position that all people experience either depression and/or anxiety a various points in their lives and it is normal to do so.)
- Anxiety
- Dizziness or Inner Ear Problems
- Epilepsy or Seizure Disorder
- Fatigue  
(describe) \_\_\_\_\_
- Plantar Fasciitis
- Glaucoma
- Headaches -- How often? \_\_\_\_\_ Migraines?    Yes    No
- Heart Challenges  
(describe) \_\_\_\_\_
- Liver conditions
- Hernia
- Herniated, Bulging or Degenerated Disc: Which disc(s) \_\_\_\_\_
- Neck problems
- Scoliosis
- High Blood Pressure---Is it controlled?    Yes    No
- Immune Challenges?  
Describe \_\_\_\_\_
- MS
- Osteoporosis
- Fibromyalgia
- PMS/ Difficulty with periods
- Sinus, lung or bronchial issues
- Stroke
- Ulcers
- Numbness or tingling? Where \_\_\_\_\_
- Other?  
Describe \_\_\_\_\_

Are there any areas of your body which seem to give you pain or discomfort on an occasional basis? \_\_\_\_\_

\_\_\_\_\_