CONFIDENTIAL INFORMATION REQUEST

Association for Yoga Studies

NAME: HOME TEL:

ADDRESS: WORK TEL:

E-MAIL:

DATE OF BIRTH: OCCUPATION:

1. Please circle any area where you have pain or there is a problem.
   Is this a recent development or a chronic problem?

2. Please describe briefly, any movement that might cause problems for you.
   (Draw stick figures if possible).

3. Please tick any of the following if you have a history with: O = Old C = Current

	O	C		O	C		O	C
Anaemia			Diabetes			Heart problems		
Anxiety			Digestive Problems			Insomnia		
Arthritis			Disc Problems			Menstrual difficulties		
Asthma			Dizziness			Migraine		
Back pain - low/mid/neck			Eliminative problems			Premenstrual symptoms		
Blood pressure - low/high			Epilepsy			Respiratory problems		
Cancer			Eye problems			ANY OTHER		
Circulation problems			Hay Fever					
Depression			Hearing Problems					

4. Please indicate if you have had any recent injuries, illnesses, operations, or if you are pregnant.

5. Are you currently receiving treatment from a doctor?
   If yes, please indicate for what, and if any medication has been prescribed.

6. Have you done yoga before? If 'yes', please give details.

7. Apart from Yoga, what other disciplines, sports or activities are you involved with?

8. How did you hear about this class?

9. What would you like to see from your work with Yoga?