**Hatha Yoga by Susan**

**Medical Profile**

Forename………………………………………………………. Surname……………………………………………………….

Address……………………………………………………………………………………………………………………………..….

Date of Birth…...……………………... Mobile No………………………………………………………………………………....

Email…………………………………………………………………………………………………………………………………….

Emergency contact………………………………………………... tel no…………………………………………………………

Occupation……………………………………………………………. GP ………...………………………………………………

Have you studied Yoga before? Y/N Details……………………………………………………………………………………...

What are you hoping to gain from Yoga classes?...................................................................................................

How did you hear about the Yoga Classes?...........................................................................................................

*The following information is treated as confidential. Please* ***tick*** *the box if you experience any of the following conditions and provide details that may affect your ability to do yoga.*

|  |  |  |  |
| --- | --- | --- | --- |
| Difficulty with physical exercise | Advised by Dr not to exercise | Joint/mobility problems | Heart problems/chest pain/stroke/angina |
| Back pain | Sciatica | Respiratory problems | Diabetes |
| Epilepsy | High/low Blood pressure | Faint/dizzy spells | Arthritis |
| Headaches/migraine | Multiple Sclerosis | M.E./Lupus/Chronic Fatigue | Fibromyalgia |
| Scoliosis | IBS/Colitis/Crohn’s | Plantar Fasciitis | Hiatus Hernia |
| Depression/Anxiety | Insomnia/sleep disturbances | Hearing problems | Eyesight problems |
| Do you smoke | Pregnant | Given birth within past 6 months | Surgery in last 2 years |

Please give further details if you have ticked any of the above boxes or suffer from any other health problem which may affect your yoga practice………………………………………………………………………………………………………………………….

Medication ………………………………………………………………………………………………………………………………….

**Client Declaration**

I take full responsibility for my own health and wellbeing during the class and for my own safety I will inform the teacher at the beginning of the class should any changes to my medical information occur or if any medical, physical or emotional problems arise while attending the class.

**Signed…………………………………………………………………. Date …………………………………………………….**

**(if under 16 Parent/Guardian Signature required) Instructor……………………………………………….**