BWY HEALTH QUESTIONNAIRE

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| To be completed by yoga class participants. All information given will be treated in the strictest confidence and storedin accordance with Data Protection legislation. |
| **Name:** |  |
| **Date of Birth:** |  |
| **Address:** |  |
|  |
| **Telephone:** | **Home:** |
| **Mobile:** |
| **Email:** |  |
| **Emergency contact name:** |  |
| **Emergency contact tel. no:** |  |
| **Have you attended a yoga class before?** |
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| **If yes, how long have you practiced yoga and what style of yoga have you practiced?** |
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| The following information is required to ensure your safety. Whilst yoga may be practised safely by most people, there are certain conditions which require special attention. If you are unsure, please consult your GP before commencing class. Please tick the boxes below if you have any of the following medical conditions. |
| **These conditions require specific modifications to your yoga practice. If yes, please give details.** |
| Abdominal disorder or recent surgery |  | Arthritis (osteo or rheumatoid) |  |
| Unspecified back pain/ problems |  | Spinal injury |  |
| Joint replacement |  | knee problems |  |
| hip problems |  | shoulder or neck problems |  |
| heart disorders |  | high blood pressure |  |
| low blood pressure |  | Other |  |
| **Further information:** |
| **These conditions may affect your practice and so provide useful information for your tutor.** |
| Asthma |  | Diabetes |  |
| Anxiety/depression |  | Auto-immune disorder (e.g. M.E. M.S. Lupus etc.) |  |
| Epilepsy |  | Balance affecting disorder |  |
| Respiratory issues |  | Migraine |  |
| Sensory disorder affecting eyes or ears |  | Other (discuss with tutor) |  |
| **Further information:** |

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| **Please tick this box if you do not wish to declare medical information** |  |
| **Have you had any recent operations (in the last two years)?** |
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| **Do you have any old injuries that still trouble you? Or any other medical conditions not covered above that might****be adversely affected by yoga practice?** |
| **Are you /could you be, pregnant, or have you given birth in the last six weeks?** |
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| **Do you participate in any other physical activity, e.g. gym, jogging, swimming, aerobics, cycling, walking or other?** |
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| **How regularly do you do this?** |
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| **How did you hear about this class?** |
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| **DECLARATION** |
| I confirm the above information is correct and that I take responsibility for my own health and safety whilst participating in the yoga class. I also understand that it is my responsibility to:* check with my doctor if I have any difficulties or concerns about my ability to participate in the yoga class
* advise the yoga tutor of any change in my medical information or ability to participate in the yoga class
* follow the advice given by my doctor and/or yoga tutor
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| **Name (please print):** |  |
| **Signed:** |  |
| **Date:** |  |

In order to comply with the General Data Protection Regulations, it is necessary to check whether, or not, you are

happy for me to retain your contact details, and to email you information I think will be useful to you, including training and events, and relevant updates. I only hold information when it is necessary for me to carry out my work, and when you have given me permission to do so.

To ensure that I only communicate with you in the manner of your preferred choice, can you please indicate below your preference(s) or otherwise, when contacting you.

Please note that you are able to amend these choices at any time by contacting your tutor.

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| **Means of communication** | **YES** | **NO** |
| Post |  |  |
| Email |  |  |
| Mobile phone (text/SMS) |  |  |