Blissful Body Yoga
discover your bliss!

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CONFIDENTIAL HEALTH INFORMATION FORM

Thank you for taking the time to provide this information that will help me to provide adaptations as needed so that your yoga practice is safe appropriate for you. ***Use the bottom or back of this sheet if you need more space.***

1. Please check the word that best describes the current state of your health:
______ Great ______ Good ______ Average ______ Poor

2. Please check any that apply and give detail:

- ❑ Back pain. Please specify location and movements that aggravate/relieve.______________________________
- ❑ Joint pain, instability or restriction of movement. Please give location and describe any movements that aggravate/relieve: hip / knee / ankle / foot / neck / shoulder / elbow / wrist / hand / other:
  ____
  ____
  ____
- ❑ Sports-related injuries or conditions. Location and any movements that aggravate/relieve.
  ____
- ❑ Muscle tightness. Location and movements that aggravate/relieve. ________________
- ❑ Injuries with date.__________________________
- ❑ Arthritis. Please specify affected joints and any movements that aggravate/relieve.
  ____
- ❑ Scoliosis or other orthopedic conditions or surgeries.
  ____
  ____
- ❑ Leg cramps. Please specify location and when they tend to occur:
  ____
- ❑ Heart conditions. Please specify:
- ❑ High blood pressure, (hypertension)
  If so, is it medicated?_________ Normalized by medication? __________
- ❑ Low blood pressure.
- ❑ Surgery. Please specify and give approximate date:
  ____
- ❑ Cancer
- ❑ Varicose veins
- ❑ Hernia
- ❑ Respiratory conditions
- ❑ Asthma
- ❑ Allergies
- ❑ Digestive problem
- ❑ Diabetes
- ❑ Hypoglycemia
- ❑ Anxiety
- ❑ Difficulty sleeping
- ❑ Glaucoma
- ❑ Detached retina
- ❑ Hearing loss
- ❑ Thyroid/endocrine problem
- ❑ Chronic pain/ fibromyalgia
- ❑ Epilepsy
- ❑ Headaches
- ❑ Migraines
- ❑ PMS
- ❑ Discomfort with menopause
- ❑ Pregnancy (due date)

4. Please describe any other health or medical conditions:

5. Please list all medications, herbs and supplements you are currently taking:

6. Please ask any questions or voice any concerns that you may have about participating in yoga classes:

7. Do you drink soft drinks? How many per day?
8. Do you drink caffeinated drinks? How many per day?
9. Do you drink alcohol? How many per day?
10. What are your general eating habits like?

Signature: ______________________________ **Date:** _______

Print Name: ____

Email: ____