

DIVINE LIGHT

your own guide awakens™

Health and Lifestyle Questionnaire

Name: _____ M/F _____ Birthdate: _____ Current age: _____

Address: _____ City, Province _____ Postal Code _____

Phonenumber: (h) _____ (w) _____ (cel) _____

E-mail: _____

In case of emergency please notify:

NAME: _____ PHONE/CELL: _____

NAME: _____ PHONE/CELL: _____

Occupation _____

Types of yoga interested in _____

Prior experience _____ Preferred yoga package _____ Time slots preferred _____

What do you hope to achieve from this class _____

Health Assessment

MEDICAL HISTORY

* Note: after completing this questionnaire, in the future please inform the trainer at the beginning of a session or contact her/him previous to a session if ANY condition of your health change for any reason.

Please check if you have/have had any of the conditions listed and provide details on the line indicated (date, type):

Heart Disease/Heart Attack (date) _____

Hypertension (BP) _____

Chronic Pulmonary Disease (Empysemia, Bronchitis) _____

Asthma/Exercise Induced Asthma _____

Arthritis (where) _____

Osteopenea/osteoporosis (list bone density test results, if known) _____

Diabetes (Type I or II) _____

Diphtheria _____

Stroke (date and cerebral location) _____

Epilepsy _____

- Varicose Veins (if treated, list frequency) _____
- Back Pain (upper, mid, lower; when occur) _____
- Hernia _____
- Dizziness/Fainting(frequency) _____
- Chronic nose bleeds _____
- Chronic headaches (frequency) _____
- Skin conditions (type, degree) _____
- Stomach/digestive problems _____
- Surgery _____
- Cancer (skin, breast, prostate, etc) _____
- Psychological conditions (e.g., depression, anxiety) _____
- Autoimmune condition (e.g., Lupus, rheumatoid arthritis) _____
- Thyroid dysfunction (hypothyroid, hyperthyroid; medication) _____
- Bone/Joint Problems(e.g., past breaks, soreness) _____
- Muscle/Tendon Problems (e.g., tendonitis, tears) _____
- "Trick" or locking joints _____
- Dislocating joints (shoulder, hips) _____
- Other (specify) _____

Cholesterol (if known) _____ Blood Pressure (if known) _____

If you are currently taking ANY medications, vitamins, supplements, please list them here (with dosage): _____

Allergies (food, airborne, pharmaceuticals, etc.) _____

Are you pregnant or planning to become pregnant (within a year)? Y N

Do you smoke? Yes No If yes, amount _____ for _____ number of years.

Were you a smoker and have quit? Yes No How long since your last cigarette? _____

PHYSICAL FITNESS PROFILE

If you are presently following a physical fitness program please describe:

Activity(ies) (e.g., weight machines, home program, walking, gardening, aerobics, yoga, etc.)

Number of times per week _____ Time to complete the activity _____ Weeks/months active _____

All the above information is required so as to make sure we tailor a personalized program that will best suit your requirements. All personal information will remain strictly confidential.

Please print and bring it with you to your session