

GORDON WAX YOGA

NEW STUDENT QUESTIONNAIRE-CONSULTATION FORM

Please filled out prior to joining a yoga class, and sign disclaimer

All information given will be treated in the strictest confidence and stored in accordance with Data Protection legislation.

Name

Address

Telephone number Home Mobile

e-mail

Emergency contact name and tel. no

Have you attended a yoga class before?

If yes, how long have you practiced yoga?

If yes, what style of yoga have you practiced? (if known)

How did you hear about this class?

Do you participate in any other physical activity, e.g. gym work, jogging, swimming, aerobics, cycling, walking or other?
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How regularly do you do this?

Are you happy to be adjusted in class (hands on)?

The following information is required to ensure your safety. Whilst yoga may be practised safely by the majority of 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 | <input type="checkbox"/> |
| arthritis (osteo or rheumatoid) | <input type="checkbox"/> |
| back pain (if known cause please state) | <input type="checkbox"/> |
| knee problems | <input type="checkbox"/> |
| hip problems | <input type="checkbox"/> |
| shoulder or neck problems | <input type="checkbox"/> |
| heart disorders | <input type="checkbox"/> |
| high blood pressure | <input type="checkbox"/> |
| low blood pressure | <input type="checkbox"/> |

These conditions may affect your practice and so provide useful information.

- | | |
|---|--------------------------|
| asthma | <input type="checkbox"/> |
| diabetes | <input type="checkbox"/> |
| auto-immune disorder (e.g. M.E. M.S. Lupus etc) | <input type="checkbox"/> |
| epilepsy | <input type="checkbox"/> |
| anxiety/depression | <input type="checkbox"/> |

sensory disorder affecting eyes or ears
balance affecting disorder
other (to be discussed with tutor)

Can you describe you current mental health?

Do you smoke

How many per day

Do you drink alchahol

How much per day

Are you /could you be, pregnant, or have you given birth in the last six weeks? Yes/No

Are you menstruating at the moment ?

How much water do you drink?

How many hours sleep to you get per night?

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?

Yes/No

If yes, please provide details.

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Have you had any recent operations (in the last two years)? Yes/No

If yes, please advise what the operation was.

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GP Name
GP Address
GP Tel. no

I confirm the above information is correct. I 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
- follow the advice given by my doctor and/or yoga tutor.

Name (please print).....

Signed..... Date.....

Gordon Wax Yoga

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