GENERAL HEALTH QUESTIONNAIRE - CONFIDENTIAL DOCUMENT

Name.....

Address.....
.
.....

Tel..... **Email** ....

IT IS IMPORTANT THAT YOU DECLARE WHETHER YOU HAVE / HAVE HAD ANY OF THE FOLLOWING

Please **CIRCLE** any conditions which apply to you and **TICK BOXES**	**YES**	**NO**	**MEDICATION?**
STRUCTURAL DAMAGE : injuries, strains, sprains, broken bones, operations etc HEAD : NECK : SHOULDER: ARM : ELBOW : WRIST : HAND : BACK / SPINE : HIP : LEG ; KNEE : ANKLE : FOOT : OTHER..... Brief information.			
HYPERTENSION (High Blood Pressure) **HYPOTENSION** (Low blood pressure)			
HEART DISEASE (e.g. Angina**)** **HEART ATTACK**. When?			
EPILESY Minor / Major. **STROKE** When?			
MULTIPLE SCLEROSIS **CANCER** When? Where?			
DIGESTIVE problem e.g. **COLITIS** **THYROID** – **Hyper / Hypo** N.B. Bring medication to class			
GLAUCOMA **DETACHED RETINA** other.**EYE problem**			
EAR problem **DEAFNESS** hearing aid? **MENIERE'S DISEASE**			
DIABETES Diet controlled / inject insulin N.B. bring medication to class			
CHRONIC FATIGUE SYNDROME **M.E.** **HIV POSITIVE**			
ALLERGIES N.B. bring medication to class			
ASTHMA other **BRONCHIAL** problem N.B. bring medication to class			
NOSE BLEEDS **VARICOSE VEINS** **HEADACHES / MIGRAINES**			
PREGNANCY if YES how many weeks?..... **Have you had a baby in the last 12 months?.....**			
ANY OTHER CONDITION?			

CONSENT FORM **(N.B. None of this information will be used for marketing purposes)**

I confirm the above information is current and accurate
I consent to Judith Jones holding the above information for the purpose of maintaining a data base and to help her take into consideration any health issue for my safe practice of the yoga asanas and pranayama.

Signed.....**Print Name**..... **Date**.....