Health and Physical Activity Form

Name:_________ ____
Address:____
Birthdate:______ Sex:_____ Height:_____ Weight:____
Phone: ___________________________________
Emergency Contact: _________________________ Phone: _____________________
Physician's Name: ___________________________ Phone: _____________________

Please check if applicable:

Diabetes __	Heart Murmur __	Irregular Heart Beat __
High Blood Pressure __	Respiratory Infections __	Respiratory Infections __
High Cholesterol __	Angina/Chest Pain __	Smoke __
Aneurysm __	Stroke __	Heart Attack __

If yes to any of the above, please describe:
____
____
____

Do you have any of the following conditions?

___Ankle/Foot Injury	___Knee Injury	__Hip Injury
___Arm/Elbow Injury	__Shoulder Injury	___Head/Neck Injury
___Calcium Deposits	___Tennis Elbow	___Nerve Damage
___Other		

Has your doctor ever advised you against exercise? __Yes __No
Are you presently receiving Physical therapy? __Yes __No
If yes, why?

Are you presently taking any medications? __Yes __No

If so please list the names of each.

____

____

Are you involved in an exercise program at this time? Yes __No __

If yes, please describe ____

____

How would you rate the amount of physical activity in your daily life? Very Little __Little __Moderate __Active __Very Active__

How would you rate the stress of your job? Little __Moderate __Stressful__
What are your personal exercise program goals?
Weight Control/Loss __Staying in Shape __Stress Reduction __Increased Strength __Cardio Conditioning __Other__
Have you ever practiced yoga before? Yes __No__
If so, what kind? ____ How long have you been practicing _________________________________ Please rate your experience;
Beginner __Intermediate __Intermediate/Advances __Advanced__

From 1 to 5, rate the following aspects of yoga practice in order of importance to you. (1 being the most important)
Physical Practice/Asana __Breathing Techniques/Pranayama __Meditation/Dhyana__

What brings you to yoga practice at this time?

Additional comments or information.