

**Well-Woman Health Questionnaire**

**Name:**

**Date of Birth:**

**Address:**

**Mobile Number:**

**Email Address:**

**Emergency Contact Name:**

**Emergency Contact Number:**

**Doctors Name:**

**Surgery Telephone Number:**

**Surgery Address:**

**Menopause Symptoms & Medication or Practices used to help with symptoms:**

**Other Health Conditions/Details (including pregnancies/operations/injuries):**

**Are you on any other Medication? If so, please provide details:**

**Food/General Allergies:**

**Yoga Experience:**

**What do you hope to gain from your Well-Woman Yoga Practice?**

I declare that the information I have given here is correct and as far as I am aware I can participate in yoga classes/1:1 sessions.

I understand that it is my responsibility to inform the teacher of any health situation/ problems.

I understand that my body is my responsibility, and that should I be uncomfortable or in pain during an exercise I need to talk the yoga practitioner at the time so that suitable variations can be provided.

I understand that this form is strictly confidential, and is solely for the use of the yoga practitioner to help provide a safe environment within classes & 1:1 sessions.

Signed:

Print Name:

Date: