



# The Yoga Connection

620 Edgar Avenue · Beaumont, California 92223

## New Student Health Form

Welcome. We look forward to working with you. Because yoga can address the spectrum of human issues and challenges, including and beyond physical pain and injury, we ask that you please answer these questions. Please note that all of your personal information will be kept confidential.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ cell: \_\_\_\_\_

Email: \_\_\_\_\_ Age: \_\_\_\_ D.O.B (D/M/Y): \_\_\_\_\_ Sex: M / F

Emergency Contact (Name & Phone #): \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

### Yoga Practice Experience

1. Have you practiced yoga before? YES NO

2. If yes, how often do you practice?

3. Styles of yoga practiced (circle all that apply):

Ashtanga      Bikram/Hot      Gentle/Restorative      Hatha      Iyengar  
Kundalini      Power      Restorative      Vinyasa/Flow      Other

### Goals

What do you hope to gain through Yoga? (circle all that apply and feel free to add)

#### Physical:

strength training      injury recovery      flexibility  
weight management      mental focus

#### Mental/Emotional:

depression      anxiety      recovery and/or maintenance      grief  
changing or improving health/behavior habits      Spiritual - please describe

#### Yoga practice improvement:

asanas      alignment/balance      pranayama/breathwork,      meditation

#### Other:



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## Health Questionnaire

Are you presently under the care of a medical doctor or health practitioner? \_\_\_\_\_

Do you have any restrictions in movement? (please describe) \_\_\_\_\_

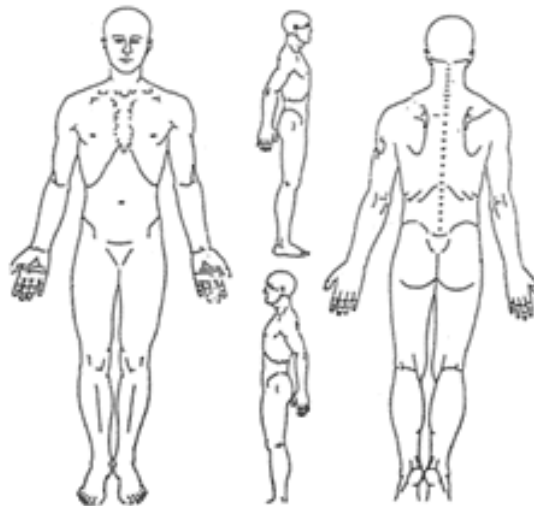
Describe your usual physical activity. \_\_\_\_\_

Please indicate any of the following that apply to you:

- |   |   |
|---|---|
| <input type="checkbox"/> Back pain          | <input type="checkbox"/> Headaches                  |
| <input type="checkbox"/> Depression/anxiety | <input type="checkbox"/> Joint problems             |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Menstrual problems         |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Pregnancy- Due date: _____ |
| <input type="checkbox"/> Fractures          | <input type="checkbox"/> Tooth/ Jaw pain            |
| <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Trouble with balance       |

Please indicate any areas of pain by labeling them on the diagram below.

<b>A</b> = Ache	<b>B</b> = Burning	<b>N</b> = Numbness	<b>P</b> = Pins & Needles
	<b>S</b> = Stabbing	<b>O</b> = Other	



Signature \_\_\_\_\_ Date: \_\_\_\_\_