Personal Information:

Name:_____Date of Birth_____
Email:_____Phone_____
Local emergency contact name/number_____

Your Personal Goals or Intentions of Yoga Practice:
1._____
2._____
3._____

How Many hours of sleep do you get per night?_____
How often do you wake up at night?_____

Health Conditions:
Do you have or have you had

Cardiovasultar Disease Yes____ No_____

Hypertenison Yes_____ No_____
Hypotension Yes_____ No _____
Vertigo Yes_____ No_____
Asthma Yes_____ No_____
Allergies Yes_____ No_____
Neurologial Condition Yes_____ No_____
Osteoporosis Yes_____ No_____
Arthrisis Yes_____ No_____

Current Exercise Routine:
Do you exercise regulary: Yes_____ No____
Do you sit for long hours at a computer or driving Yes_____ No___

Current stress level on a scale of 0-10 (1being calm, 10 overwhelmed)
_____
How do you currently help lower your stress level_____
_____