Health and Physical Activity Form

Name:_____ _____
Address:_____
Birthdate:_____ Sex:_____ Height:_____ Weight:____
Phone: _____

Emergency Contact: _____ Phone: _____
Physician's Name: _____ Phone:
_____

Please check if applicable: Diabetes __
High Blood Pressure __ High Cholesterol __ Aneurysm __

Heart Murmur __ Respiratory Infections __ Angina/Chest Pain __

Stroke __

Irregular Heart Beat __ Respiratory Infections __ Smoke __

Heart Attack __

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

Do you have any of the following conditions?

___Ankle/Foot Injury ___Arm/Elbow Injury ___Calcium Deposits ___Other

___Knee Injury __Shoulder Injury ___Tennis Elbow

__Hip Injury ___Head/Neck Injury ___Nerve Damage

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.