





## Being in Yoga

### Lifestyle:

Occupation:

Stress: please rate on scale of 1 -10 (1 lowest, 10 highest)

Do you exercise?

What type?

How many times per week?

Do you smoke? \_\_\_\_\_

Do you have children?

### FOR WOMEN ONLY:

Are your periods regular? Yes No

Are your periods painful? Yes No

Have you reached menopause? Yes No

Are you pregnant? Yes No

How many weeks?

### IF PREGNANT, do you suffer from any of the following?

Sciatica Yes No Occasionally

Low back pain Yes No Occasionally

Dizziness Yes No Occasionally

Nausea Yes No Occasionally

Heartburn Yes No Occasionally

Gestational diabetes Yes No

High Blood Pressure Yes No

Other issues:

What do you expect from yoga?

Thank you for taking the time to fill out this form.