Professional
Health Solutions
exercise physiology yoga acupuncture

Isabel Gordon Bsc(Hons) Adv Dip TCM
Traditional Chinese Medicine Practitioner
Accredited Exercise Physiologist
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Yoga Pre-Exercise Screening Form

Name
Email Address
Address
Phone
D.O.B

Do you have any medical conditions which may affect your participation?

_____

Are you pregnant ? Y N
Have you had a baby in the last six months ? Y N
Do you smoke ? If YES, how may per day? _____ Y N
Are you presently taking any medication or natural medicine? Y N
If YES, please list names and dosages of _____

_____

Are you aware of any injury, past or present, which may be aggravated by any form of exercise ? Y N
If YES, please explain _____
Do you have any previous experience with yoga? Y N
What type of class do you prefer? Physically active. gentle, slower. Lots of relaxation, breathing & meditation.
What are your short and long term health and goals ?
Short _____

_____

Long _____

_____

How did you hear about the yoga class ?_____

Are you in a health fund? Y N Which one?_____

Please inform me if you feel any discomfort during the class. No responsibility can be taken for injuries from, or as a consequence of your participation in these classes.

Signed_____Date _____/_____/20____

P 02 6676 3783 M 0412 636 950
60 Cabarita Rd Bogangar NSW 2488
W www.cabaritabeachyoga.com
E isabel.healthmatters@gmail.com