# INNER PEACE YOGA

**211B-3521 8th Street East 306-664-YOGA (9642)**

## HEALTH FORM

Please check and, if appropriate, describe in the space provided any of the following conditions that apply to you:

___ARTHRITIS
___ASTHMA/BREATHING
___PROBLEM DIABETES
___DIGESTIVEPROBLEMS/COLITIS/ DIARRHEA
___EYE PROBLEMS/GLAUCOMA /DETACHED RETINA
___EPILEPSY
___HEARING/EAR PROBLEMS
___HEART CONDITION
___HIGH BLOOD PRESSURE - is it ___controlled?
___HYPERTHYROID
___KIDNEY/BLADDER
___LOW BLOOD PRESSURE
___OSTEOPOROSIS
___PREGNANT, due date
___SINUS CONDITION

_____

_____

_____

_____

Do you have numbness or pain in :

___neck ___wrists ___knees
___shoulders ___hips ___ankles
___elbows ___lower back ___feet
___hands ___upper back ___other

Please describe: _____

_____

Is there any other reason why you should do limited physical activity? _____

_____

Are you currently being treated for any of these conditions? _____ by whom?
Physician ____ Naturopath____ Acupuncturist____ Osteopath____
Physiotherapist____ Chiropractor____ Other, please specify: _____

If needed and after discussion with you, may I contact him/her to consult about your yoga practice? YES NO (Please circle response)

Name & Phone# of Physician_____