Celeste Cronin
Yoga Therapist and Teacher

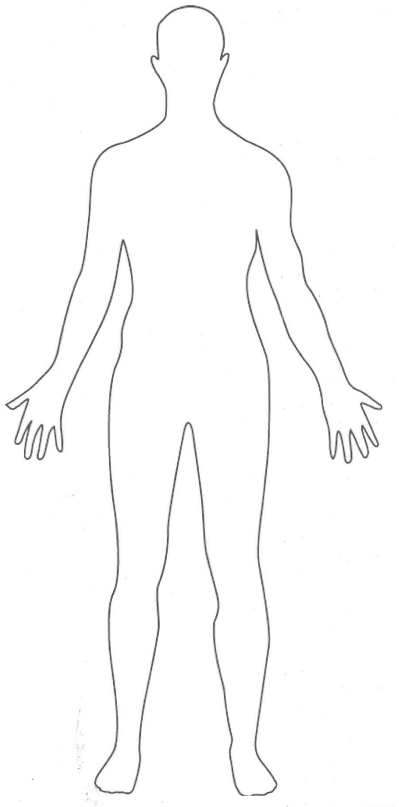
CONFIDENTIAL INFORMATION REQUEST

Name: Date of birth:

Occupation: Address:

Tel Home:

Email: Work:



1. Please circle any area where you have pain or there is a problem.
2. Describe any movement which may cause discomfort

2. Please tick if you have a history with: If it is current please tick second box.

Anaemia			Depression			Hay fever		
Anxiety			Diabetes			Hearing problems		
Arthritis			Digestive problems			Heart problems		
Asthma			Eliminative problems			Insomnia		
Back pain-low/mid/ neck			Epilepsy			Menstrual difficulties		
Blood pressure – high/low			Eye problems			Migraine		
Cancer			Disc problems			Pre-menstrual symptoms		
Circulation problems			Dizziness			Respiratory problems		

3. Please indicate if you have had any recent injuries, illness, operations or are pregnant.

4. Are you under treatment by a doctor? What for and what medication are you taking?

5. There any personal difficulties which could be exacerbated by yoga practice?

6. Have you any previous yoga experience?

7.What other disciplines, sport or activities are you involved in?

8. What would you like to gain from your work with yoga?

Signed and dated