PREGNANCY YOGA QUESTIONNAIRE

Claria Yoga

**** Please answer all questions in this form and return it to me before your first class ****

Please provide me with any valuable information that will help me to plan a yoga class that is beneficial to you and safe for you.

Contact information

Name: .....

Email: .....

Home telephone: .....

Address: .....

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Mobile: .....

Your pregnancy

Due date: .....

Planned place of birth: .....

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About your pregnancy *(Please give details)* .....

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Your health

Do you have or have you ever experienced any of the following? *(Please tick)*

- ☐ **High blood pressure**
- ☐ **Backache or pain**
- ☐ **Breathlessness**
- ☐ **Pre-eclampsia**
- ☐ **Insomnia**
- ☐ **Operations (including caesarean section)** – *(Please give details)*

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- ☐ **Low blood pressure**
- ☐ **Headaches, dizziness or fainting**
- ☐ **Diabetes**
- ☐ **Oedema (swollen limbs)**
- ☐ **Any allergies**
- ☐ **Other medical conditions** *(Please give details)*

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A little more about you

Is this your first pregnancy? ☐ Yes ☐ No

Have you ever had a miscarriage? ☐ Yes ☐ No

Do you smoke, or have you ever smoked? ☐ Yes ☐ No

Have you practised yoga before? ☐ Yes ☐ No

(Please give details) .....

Have you had any injuries either in the past or present? ☐ Yes ☐ No

(Please give details) .....

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What is your occupation? .....

Personal declaration

I declare the above information is correct and will inform you of any changes in the future.

Print name: .....

Signature: .....

Date: .....