**STUDENT QUESTIONNAIRE** *To be completed by yoga class participants for face to face and remote teaching. All information given will be treated in the strictest confidence and stored in accordance with General Data Protection legislation*

**Name** .................................................................................................DOB…………………………………..

**Address** ....................................................................................................................................................

**Telephone number** Home ............................................. Mobile .............................................................

**e-mail** in CAPITALS...................................................................................................................................

**Emergency contact name and tel. no** ....................................................................................................

What is your occupation...........................................................................................................................

Have you attended a yoga class before? If yes, how long have you practiced yoga? ...............................

If yes, what style of yoga have you practiced? (if known) ........................................................................

How did you hear about this class? ..........................................................................................................

Do you participate in any other physical activity, e.g. gym work, jogging, swimming, aerobics, badminton, cycling, walking or other?

...................................................................................................................................................................

How regularly do you do this? ...................................................................................................................

**What is your main reason for coming to yoga class**? Circle pls

e.g. EXERCISE, FLEXIBILITY, RELAXATION, PAIN RELIEF, STRESS RELIEF, PHYLOSOPHY, MEDITATION, OTHER

 …………………………………………………………………………………………….

**The following information is required to ensure your health. Whilst yoga may be practised safely by most people, there are certain conditions that require special attention. If you are unsure, please consult your GP before commencing class. Please indicate in the boxes below whether or not you have any of the following medical conditions and then provide further information:**

These conditions require specific modifications to your yoga practice. If yes, please give details.

Heart disorders/ condition 🗌

High blood pressure 🗌

Low blood pressure 🗌

Abdominal disorder or recent surgery 🗌

Arthritis (osteo or rheumatoid) 🗌

Back pain (if known cause please state) 🗌

Knee problems/knee replacement 🗌

Hip problems/ hip replacement 🗌

Shoulder or neck problems 🗌

Diagnosed Hypermobility 🗌

Further information………………………………………………………………………………………………….. PTO

These conditions may affect your practice and so provide useful information for your tutor.

Asthma 🗌

Diabetes 🗌

Auto-immune disorder (e.g. M.e. ms. lupus etc) 🗌

Epilepsy 🗌

Anxiety/depression 🗌

Sensory disorder affecting eyes or ears □

Respiratory issues 🗌

Balance affecting disorder 🗌

Other (to be discussed with tutor) 🗌

Are you /could you be, pregnant, have you given birth in the last 6weeks or had a miscarriage in the past year? Yes/No

Do you have any old injuries that still trouble you? Or any other medical conditions not covered above that might be adversely affected by yoga practice? If yes, please provide details.

……………………………………………………………………………………………………………..............

Have you had any recent operations (in the last two years) If yes, please advise details.

……………………………………………………………………………………………………………..............

**Please tick this box if you do not wish to declare medical information**

*Please be aware that your yoga teacher cannot give any modifications or alternatives that may be appropriate, for conditions that have not been declared.*

|  |
| --- |
| **Disclaimer*Please read carefully; your submission of this form will be taken to indicate your understanding and acceptance of the following:*** |
| *Please take care when filling in this form and check the contents are accurate before you submit it. By submitting this form, you are confirming that the contents are true and accurate to the best of your knowledge. Please notify your teacher of any changes to your responses in this healthcare questionnaire before participating in classes subsequent to those changes.**Neither your teacher nor the British Wheel of Yoga are qualified to express an opinion that you are fit to safely participate in any British Wheel of Yoga organised sessions or any British Wheel of Yoga trained teacher’s yoga classes. You must obtain professional or specialist advice from your doctor before participating if you are in any doubt.**All of our yoga instructors are appropriately qualified or British Wheel of Yoga Accredited teachers, with high standards of teaching and best practice. Where possible, your teacher may offer suitable modifications or adjustments and practices to suit different levels of experience and ability.**Please always let the teacher know before the class if this is your first time practicing yoga or if you are not confident about your experience and/or ability. Where you are taking part in live-streamed classes, please note that the instructor may not be able to see you at all times. Where you have declared a health condition, please contact the teacher before the class if you would like to request that you are provided with suitable modifications or adjustments wherever possible. Please note, where you are taking part in a pre-recorded class, you will not be able to request specific adjustments or modifications.* *In all classes whether face to face, live streamed remote or pre-recorded remote, always follow your teacher’s safety instructions and listen to your body. Where a movement or class is beyond your experience or ability, feels too difficult for you, or you experience any discomfort, please do not continue the movement or class.*I read and confirm the above information is correct and I take full responsibility for my own health and safety whilst participating in the yoga class, whether face to face or remote, and I also understand that it is my responsibility to:* check with my doctor if I have any difficulties or concerns about my ability to participate in the yoga class
* advise the yoga tutor of any change in my medical information or ability to participate in the yoga class
* follow the advice given by my doctor and/or yoga tutor
* take full responsibility for not exceeding my physical limitations and for any injury that might occur as a result
* only do what feels comfortable in class and not to work in pain
* to practice mindfully and safely

I understand that for any periods of time throughout a remote session during which I move off screen or are outside of the teacher’s view, whether intentionally or not; no liability will arise on the part of the teacher. |
| **Name (please print):** |  |
| **Signature***if using a printed out paper copy: Otherwise indicate with a tick or X* | …………………………………………………………………………………I confirm my understanding and acceptance of this health questionnaire and its disclaimer:  |
| **Date:** |  |

**GDPR Statement**

In order to comply with the General Data Protection Regulations, it is necessary for me to check whether or not you are happy for me to retain your contact details, and to send you information that I think may be useful to you, including training and events, and relevant updates. I only hold information when it is necessary to do so in order for me to carry out my work, and when you have given me permission to do so. To ensure that I only communicate with you in the manner of your preferred choice, please will you indicate below, your agreement, or otherwise, to the following means of communication:

|  |  |  |
| --- | --- | --- |
| **Email: YES/NO** | **Post: YES/NO** | **Telephone: YES/NO** |

****

* Additional Information to any changes to physical, mental wellbeing that you would like to disclose or any changes since you submitted your health questionnaire originally.

NAME

DATE

INFO: