

## Karuna Yoga Vidya Peetham

www.karunayoga.in +91 96865 49129 karunaayoga@gmail.com

| Name: Ms/Mrs/Mr Address: Date of Birth: Height: Weight: Weight: Email: Mobile/Landline #:    Mobile/Landline #:   |  |                                  | Health Assessm                                     |                                    |  |                |
|---|--|----------------------------------|--|------------------------------------|--|----------------|
| Date of Birth:  |  |                                  |  |                                    | Date:                                    | <u> </u>       |
| Kindly answer the following sincerely. Please underline wherever necessary:-  What is your purpose in learning yoga? i) Fitness ii) Relaxation iii) De-stress iv) Therapy v) Spiritual vi) Other  Any prior experience of yoga? If yes, where:  What is your level of fitness? i) Excellent ii) Good iii) Average iv) Poor  What do you hope to achieve from being a practitioner of yoga?  Have you suffered from any of the following conditions:  i) High Blood Pressure ii) Low Blood Pressure iii) Heart Disease/Chest Pain iv) Diabetes v) Epilepsy vi) Arthritis  vii) Asthma/Bronchitis viii) Anxiety/Depression ix) Headache/Migraine x) Insomnia/Sleeplessness xi) Hernia xii)Eye Strain Digestive Disorders like Constipation/IBS/Gastritis/Acidity/Indigestion/Peptic Ulcer/Ulcerative Colitis/Piles.  Do you suffer from: i) Over Weight ii) Under weight ii) Anger iii) Fatigue iv) Excessive Stiffness v) Neck Pain  vii) Back pain - Low back pain/Mid Back pain/Upper Back pain vii) Joint Pain - Knee Pain/Ankle Pain/ Toe pain/Hip P  (Shoulder pain/ Elbow pain/ Wrist pain/finger pain .  For Ladles only: Do you suffer from - i) Amenorrhoea iii) Dysmenorrhoea iii) Menorrhagia iv) Metrorrhagia  v) Hypomenorrhagia vi) Oligomenorrhoea viii) Polymenorrhoea viii) Premenstrual Tension  For Ladles only: Kindly mention if you are you pregnant  Have you ever had surgery? If yes, what kind of surgery and when?  Are you on any medication? If yes, for what and what type of medicine?  Have you ever had an accident? If yes, when did it happen and how you were injured?  Did you suffer with any major health problem in the past? If yes, kindly specify details with the date of occurrence.  Have you suffered from any illness in the last 3 months? If yes, kindly specify details:  | Address:   |                                  |  |                                    | / aight:                                 |                |
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