Wilmington Wellness Studio, LLC 910.796.9690

Health Screening Form

Name: _____
Address: _____
_____
Phone number: _____
Email address: _____
Date of birth: _____
Gender: _____

Have you ever been treated by a physician or experienced any of the following conditions?

___ heart disease ___ high blood pressure ___ low blood pressure
___ gastric reflux ___ glaucoma ___ orthopedic/joint problems
___ osteoporosis ___ arthritis ___diabetes
___ peripheral neuropathy (numbness/tingling/diminished sensation)

Please explain any of the above conditions in greater detail.

Are you pregnant? Yes ____ No _____Prior deliveries_____
How many weeks pregnant? Any complications thus far?
_____
_____

Prior injuries and/or surgeries
_____
_____

Do you carry a list of your current medications? Yes No

Activity level/exercise frequency at current time?
_____

Prior Yoga experience?
_____

Please list ALL emergency contacts below (including your spouse/partner, family member, friend, OB/midwife, doula, physician, etc) that should be notified in case of emergency.

Name:	Name:	Name:
Phone:	Phone:	Phone:
Email:	Email:	Email: