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# YOGA HISTORY AND GOALS QUESTIONNAIRE

**Date: _______________**

**Name: _______________________________________________**

**Are you new to yoga? _________________________________**

**What do you hope to gain from your yoga practice? _______________________________________________________**

**Do you have any known allergies to aroma therapy? ______________________________________________________**

**At times the instructor may apply a gentle touch to reposition you. Are you ok with re-alignment touch? __________**

**Please indicate any medical conditions or limitations we should be aware of? _________________________________**

**____________________________________________________________________________________________________**

**Are you pregnant? ___________________________________________________________________________________**

**Please indicate if you currently have or have had in the past (please circle all that apply):**

| | |
|---|---|
| **High blood pressure** | **Asthma** |
| **Bone/joint problems** | **Stroke** |
| **Diabetes** | **Back pain** |
| **Cancer** | **Wrist pain** |
| **Retina problems** | **Heart attack/surgery** |