POSTNATAL YOGA - STUDENT INFORMATION

NAME:

____

Emergency contact (Name, Phone Number, Relationship)

____

ABOUT YOUR PREGNANCY / DELIVERY

1. How many weeks postpartum are you? ____

2. Was this your first pregnancy? ____

3. Please give details regarding the birth: (Please circle)

C-SECTION / VAGINAL

EARLY / LATE / PREMATURE (How many days/weeks? ______________________________)

4. Did you experience any complications pre/post delivery? (Please specify)

____

GENERAL HEALTH CONDITION

5. Do you experience any of the following? (please circle)

HIGH or LOW BLOOD PRESSURE

HEART PROBLEMS

ASTHMA

ARTHRITIS

CARPAL TUNNEL

NECK PROBLEMS

BACK PROBLEMS (including Pubic Symphysis pain and/or Sacroiliac pain)

ABDOMINAL SEPARATION (Diastasis Rectus)

PELVIC FLOOR WEAKNESS (incontinence)

SCIATICA

PROLAPSE

PAIN FROM CS

EPISIOTOMY or TEARS

MASTITIS or any other breastfeeding issues (Please specify)

DEPRESSION

OTHER (please specify)

YOGA EXPERIENCE

6- Have you ever practiced yoga before? What kind? For how long?

7- Do you practice any other kind of physical activity? ________________________________

8- Anything else you think the teacher should know?

____

Please, if anything changes in the near future, let the teacher know

SIGNATURE: ____

DATE:____