



**Pregnancy Yoga Health Questionnaire**

## Thank you for completing this questionnaire.

## All your answers will be kept in complete confidence.

**Name:**  **Date of Birth:**

**Address:** **Post Code:**

**Email:**

**Contact Number:**

**Emergency Contact Name and Number:**

***Please Note*** *- It is important that we have the number of someone to contact if you need them during class.*

Would it be ok to pass your contact number on, if someone in the class asks?

**Occupation:**

**Age group:** [ ]  17-30 [ ]  31-36 [ ]  36-40 [ ]  40+

Have you done yoga before?

If yes, what type(s) and for how long?

**What is your Estimated Due Date?**

How many weeks pregnant are you?

What pre-natal screenings have you had? (Scans, amniocentesis etc)

**Is this your first pregnancy?**

How many children do you have?

How old are they?

Gynaecological/Obstetrics history (previous complications, miscarriages, IVF)

**Is this pregnancy classed as high risk?**

If yes, why?

Are you worried about any aspects of the pregnancy?

**Non-Pregnancy Related Health Issues**

**Please mark any which relate to you before you were pregnant.**

[ ]  High /Low blood pressure [ ]  Heart disease
[ ]  Epilepsy [ ]  Diabetes
[ ]  Back / neck problems [ ]  Arthritis / joint problems
[ ]  Asthma / breathing difficulties [ ]  Cancer

[ ]  Eye condition / hearing problems [ ]  Emotional/psychological problems

[ ]  Knee/Ankle problems [ ]  Recent fractures/broken bones/sprains
[ ]  Recent operations [ ]  Other

Please give details of any health conditions and how they affect you now:

Please give details of any medication you take on a regular basis, **and what it is for**:

## Do you have any specific health problems related to your pregnancy?

[ ]  Pelvic instability

[ ]  Pain in the pubic bone

[ ]  Constipation

[ ]  High blood pressure

[ ]  Low blood pressure

[ ]  Haemorrhoids

[ ]  Varicose veins

[ ]  Fluid retention

[ ]  Back or neck pain

[ ]  Insomnia

[ ]  Nausea

[ ]  Anxiety

[ ]  Heartburn

[ ]  Cramps

[ ]  Tiredness

[ ]  Other

**Covid-19** – Have you suffered from any lasting effects from a Covid infection or suffered with long Covid? *(If* ***Yes****, please give details)*

Is there anything else you think we should know?

*Please feel free to write down anything as it shall stay within strict confidentiality.*

**How did you first hear about this class?**

**Declaration:**

I take full responsibility for me and my baby/ies health during the classes, including any injuries. I will inform my teacher of any medical changes.

If I feel any pain or dizziness at any time during the yoga class, I will stop the activity immediately and inform my teacher.

If I have any doubts, I will seek the advice of my medical professional before proceeding with Pregnancy classes.

I understand that my email address will be used to create my Momence account for The Rocci Tree so that I am able to receive details of class bookings, cancellations, purchase receipts and newsletters.

*Please contact us if you would like more information about how we will contact you.*

**Signed**: **Date:**