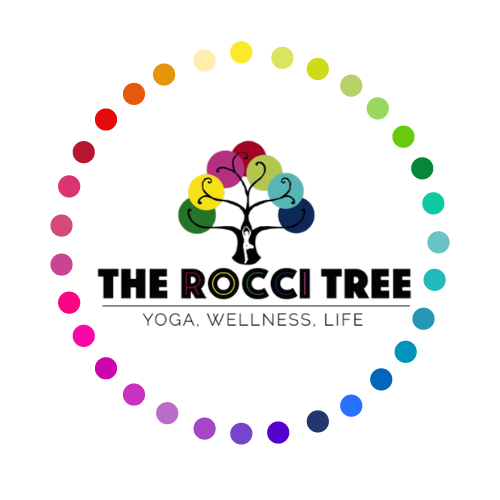
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**Well Woman Yoga Health Questionnaire**

## Thank you for taking the time to complete this questionnaire.

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

**Name:**

**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.*

**Occupation:**

**Age group:** 17-34  35-44  45-64  65+

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

**General Health Issues:** *(Please mark any which relate to you and give further details if appropriate)*

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)

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

**Well Woman Information:**

1. Which of these do you think best describes you at the moment?

I am **pre-menopausal**, still menstruating, no obvious symptoms or changes associated with the menopause

I am **peri-menopausal**, still menstruating, there may be an onset or increase in symptoms or changes associated with the menopause

I am **post-menopausal**, no menstruation for at least a year, there may still be symptoms and changes associated with the menopause

I had a **medical menopause** due to illness, surgery or treatment

I am not sure

2. Are you currently experiencing any of the following changes or symptoms?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Please say how frequent or severe you feel each one is.* | Not at all | Rarely / Mildly | Frequently / Severely | Don’t know |
| Irregular bleeding |  |  |  |  |
| Heavy / painful bleeding |  |  |  |  |
| Hot flushes / night sweats |  |  |  |  |
| Insomnia |  |  |  |  |
| Anxiety |  |  |  |  |
| Depression |  |  |  |  |
| Anger / irritability |  |  |  |  |
| Mood swings |  |  |  |  |
| Brain fog / lack of concentration |  |  |  |  |
| Joint pain / loss of flexibility / osteoarthritis |  |  |  |  |
| Loss of bone mass: osteopenia / osteoporosis |  |  |  |  |
| Loss of ability to balance |  |  |  |  |
| Poor digestion / bloating |  |  |  |  |
| Weak core muscles |  |  |  |  |
| Weak / painful pelvic floor |  |  |  |  |
| Changes in sexuality / loss of libido |  |  |  |  |
| Vaginal dryness |  |  |  |  |
| Other – please describe which other symptoms you are experiencing |  |  |  |  |

3. Have you experienced any of the following: Please tick and give numbers and year(s)

Pregnancies

Births

Vaginal Delivery

Episiotomy

Ventouse

Forceps

C-section

Abortions

Miscarriages

Stillbirth

Cot death

Other

4. Did you experience any medical problems related to your menstrual cycle?

Please tick the box if yes, and give further details

Pre-menstrual Tension Endometriosis Polycystic Ovarian Syndrome

Cervical Dysplasia Ovarian Cysts Breast Cancer

5. Did you need to seek treatment or take medication for any of the following conditions:

Please tick the box if yes, and give further details

Anxiety/Panic attacks Depression Extreme Fatigue

ME MS Auto-immune disorders

6. Have you used any complementary therapies? If yes, please give details

7. Have you practiced yoga before? If yes, how frequently and for how long?

8. Do you currently do any form of exercise? If yes, where, when & what type?

9. Are you currently in pain? (If so, can you describe how you experience pain: where in your body, when, is the pain acute or dull?)

10. How would you rate your pelvic floor tone?

Very strong Average Weak Very weak

11. Is there any other information you think might be relevant to disclose to your Well Woman Yoga teacher?

12. Is there any type of support that has been particularly helpful to you so far?

13. What is your main objective to achieve with your Well Woman classes or sessions?

**DECLARATION**

I take full responsibility for my health during the classes, including any injuries.

I will inform my teacher of any medical changes.

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:**