



Confidential Medical History

SSCY Yoga Teacher Training

Name:	Date:
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Please answer the following as accurately as you can.

In the boxes provided write “C” if the condition is current or “P” if the condition is in the past. If the condition is in the past please include the year.

Condition:	C or P	Year
Diabetes		
Coronary Heart Disease		
Epilepsy		
Hypertension		
Asthma or Respiratory Restrictions		
Anemia		
Gastro-Intestinal & Digestive Disorders (Crohn’s, IBS, Ulcerative, Colitis)		
Autoimmune Disorders (Chronic Fatigue, Rheum Arthritis, etc.)		
Gynecological Disorders		
Neurological Disorders & Symptoms (nerve pain, numbness, tingling)		
Cancer		
Depression		
Bipolar		
OCD or other Anxiety Disorder		
Seizures		
Chemical Dependency (nicotine, alcohol or drugs)		
Eating Disorders (Anorexia, Bulimia etc.)		
Sleeping Difficulties		
Chronic Constipation		
Allergies		
Glaucoma		



Please answer the following questions and explain any “yes” answers in detail in the area provided.

	Yes	No
Muscular-Skeletal Disorders or Injuries (i.e. car accidents in the last 5 years chronic knee, hip or back problems, fractured or broken bones, torn ligament/tendons, spine or disc disease or condition).		
If yes:		
Major surgeries within the last 10 years?		
If yes:		
Severe shock, trauma or ongoing stress in the past year (i.e. death, miscarriage, pregnancy, divorce, loss of job, etc.)		
If yes:		
Pregnancy		
If yes, indicate the number of weeks at the start of the program and any known complications.		
Are there any other issues that we should be aware of?		



On this page please describe how your medical condition is being managed. Include what forms of treatment you are following (physical therapy, counseling, chiropractic, diet, herbs and others).

It is important to include ALL prescribed medications.

Describe how your practice of yoga is affected or modified by your medical condition.

