THE EXPANDING LIGHT
ANANDA YOGA AND MEDITATION RETREAT

The Expanding Light
14618 Tyler Foote Road
Nevada City, CA 95959

Phone: (800) 346-5350
or (530) 478-7518
Fax: (530) 478-7519
info@expandinglight.org

Questionnaire for the Ananda Radiant Health Training

In order to help serve you better during your stay, please take a moment to tell us a little bit about yourself. Please fill out and send this form and the below medical questionnaire to us in one of these ways:

Mail: The Expanding Light, Attn: Reservations
14618 Tyler Foote Rd
Nevada City, CA 95959
Fax: 530-478-7519
Email: info@expandinglight.org

All responses are confidential.

Name ____

Name you prefer to be called _______________________

Address ____

____

Phone: Home (_______) ________________________ Work (_______) ________________________

Fax: (_______) ______________________

E-mail ____________________________________

1. Dates of the course you will be attending: ____

2. How did you first find out about this course? (web search, ad in *Yoga Journal*, friend, etc.)

3. Please tell us your reasons for taking this course.

To help us better serve your needs, we would like to know more about your lifestyle.

4. What is your occupation?
How long have you been in your current occupation?
How many hours a day to you spend at your job?

5. How would you describe your current diet (ex. whatever is around, fast food, meat & potatoes, mostly vegetarian, vegetarian)?

6. Do you exercise regularly?
   If so, what type of exercise do you enjoy?
   How often do you exercise?

7. Do you practice yoga postures regularly? **Yes/No**

   If yes, what style, how often, and how long do you practice? ____

8.Do you practice meditation regularly? ***Yes / No***

   If yes, what style, how often and how long do you practice? ____

Use a separate page to share any other information or concerns you may have.

Medical Questionnaire

All responses are confidential. We use this information only to better assist you during the course, not to screen participants (unless participation would be medically inadvisable). Attach additional sheets if necessary.

Name ____ Date of Birth _____________

☐ Male ☐ Female Height ________ Current Weight ____________ Ideal Weight __________

1. Please briefly describe your current overall health.

2. Describe any history (include dates) of back/spine/neck problems, and indicate whether they still give you problems. *Please be specific*.

3. Describe any history (include dates) of joint problems (knee, hip, shoulder, etc.), including joint repair/replacement surgeries. *Please be specific*.

4. Blood pressure (circle one): ***High / Low / Normal*** . When was it last checked? __________

   Are you currently taking blood pressure medication? ***Yes / No***. If so, how regularly?_________

   Is you medication working for you? **Yes / No**. If no, please describe:______________________

   ____

5. Describe any history (even if you are just "at risk") of cardiovascular problems.

6. Circle any of the following difficulties you have had and explain relevant specifics: ***Diabetes / Stroke / Osteoporosis-Osteopenia / Chronic headaches / Ulcers / Seizures / Allergies / Asthma / Cancer / Anxiety /Depression / Frequent dizziness*** / Other:

7. Women: Are you pregnant? ***Yes / No***. If so, when is your baby due? ______________

   Are you experiencing any menopause symptoms? **Yes / No**

8. Do you have any mental health issues, disabilities, limitations, dietary restrictions,? If so, please explain.

9. Are you currently seeing a physician or therapist for any physical or psychological conditions? ***Yes / No***.
If yes, what conditions?

Are these visits helping you? Please describe:

10. Are you now taking medication for any physical or psychological conditions? ***Yes / No***.
If yes, what medications you taken for which conditions and with what frequency? (*If you have asthma medications and/or nitroglycerine, please keep them with you at all times during the course.*)

11. Have you ever had an alcohol or substance abuse problem? **Yes / No.** If yes, please explain:

12. Have you ever been in an alcohol or substance abuse program, or any other program for mental or physical abuse? **Yes / No.** If yes, please explain:

13. Do you smoke? **Yes/No.** If yes, how many packs/day?________________________

14. Do you consume alcohol? **Yes / No.** If yes, how much?

Use a separate page to share any other information or concerns you may have.

I hereby certify that the above information is correct to the best of my knowledge, and I will continue taking all medications as prescribed by my physician(s) while staying at The Expanding Light:

____________	________________________________	________________________________
DATE	PARTICIPANT'S NAME	PARTICIPANT'S SIGNATURE