This confidential information will help your Therapist become aware of your specific needs when you work together.

Name:

Date:

Address:

Telephone:

Fax:

E-mail:

Age:

Occupation:

Do you have or have you had:
___ High blood pressure
___ Glaucoma
___ Osteoporosis
___ Seizures
___ Diabetes
___ Rheumatoid arthritis
___ Anemia
___ Heart problems
___ Asthma
___ Other breathing problems
___ Dizziness, vertigo or loss of balance
___ Unexplained falls or fractures

___ Hearing difficulty
___ Hernia/rupture
___ Unstable/ "trick" joint(s)
___ Joint dislocation
___ Metal implants/artificial joints
___ Bladder or bowel control problems
___ Pinched nerves or disc problems
___ Cancer
___ Broken bones
___ Allergies
___ Blood thinners
___ Neurological diseases
___ Headaches
___ Vision difficulties
___ Chest pain
___ Shortness of breath
___ Night sweats
___ Joint swelling2
___ Traumatic auto accidents
___ Major surgeries
___ Other chronic conditions

Women only:
___ Hysterectomy
___ Menopausal challenges
___ Caesarian delivery
___ Early termination of menses
Are you pregnant? Yes No

Additionally, please check if any of the following apply:
Back problems ___
Hernia ____
Joint Problems ____
Epilepsy ____
Fibromyalgia ____
Arthritis _____
Low Blood Pressure ____
Hypoglycemia _____

Chronic Fatigue _____
Other:

Recent Surgery:

Medications & supplements you are currently taking:

Please mention any other health or medical condition that you believe may be helpful to your Therapist and any precautions that should be taken to ensure your well-being.

Client's Notes:

1. Have you experienced other health problems or challenges in your life?

2. Do you experience pain in any part of your body – on occasion, acute or chronic?

3. Tell me a little about your lifestyle? Diet? Exercise program? Do you smoke or drink?

4. How is your breathing?

5. How would you describe your energy levels?

6. Would you describe your overall energy as stable or quite variable?

7. How is your stress level?

8. What types of situations trigger stress or bring it on for you?

9. What are some of the ways you find most effective for releasing stress?

10. Do you awaken from sleep feeling rested? Do you fall asleep easily?

11. How do you have fun in your life?

12. How well do you feel you nourish yourself – with food, love and laughter?

13. How would you describe your state of mind most of the time?

14. How would you describe your spiritual or religious life?

Yoga History

1. What is your experience with Yoga, meditation or other spiritual practices?

2. How often do you practice and is your practice regular?

3. What have you found most beneficial from these practices?

4. What have you found most difficult or challenging?

5. Have you had any previous Yoga injuries? How did they happen?

6. What do you hope to get out of Yoga practice? What is your main goal for Yoga practice?

7. Do you have any other comments/concerns?