



## Personal History

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email \_\_\_\_\_

Do you have or have you ever had: (please circle)

High blood pressure

Glaucoma

Osteoporosis

Seizures

Diabetes

Rheumatoid Arthritis

Anemia

Heart problems

Asthma

Other breathing problems/difficulties

Dizziness, vertigo or loss of balance

Unexplained falls or fractures

Hearing difficulty

Hernia/rupture

Unstable/"trick" joint(s)

Joint dislocation

Metal implants/artificial joint(s)

Bladder or bowel control problems

Pinched nerves or disc problems

Cancer

Broken bones

Allergies

Blood thinners

Neurological diseases

Headaches

Vision difficulties

Chest pain

Night sweats

Joint swelling

Traumatic auto accidents

Major surgeries

Other chronic conditions

Other: \_\_\_\_\_

For WOMEN ONLY:

Hysterectomy

Menopausal challenges

Caesarian delivery

Early termination of menses

1. How would you describe your health overall?
2. How is your diet and digestion?
3. Do you have any pain or tension anywhere in your body?
4. What kind of work do you do?
5. What do you do for exercise? Please include years of yoga experience.
6. Are you currently seeing a health care provider and what for?
7. Are you taking any prescription or non-prescription medications and what for?
8. What is your overall energy level?
9. What are your sleep patterns like?
10. What tends to bring on or trigger stress in your life?
11. How does your stress exhibit itself – anxiety, depression, anger, etc.
12. Are there habits you would like to change?
13. Do you consider yourself a spiritual individual?
14. Based on what you have answered above, do you have any goals through this work of Yoga Therapy?