French Twist Yoga

PERSONAL HEALTH HISTORY

Last Name: _____First Name:_ _____Date: _____

Address:_____City:_____State:_____Zip:_____

Phone: Home_____Work_____Cellular_____

E-mail address:_____

Date of Birth:_____Age:_____Place raised:_____

Married □ Single □ Divorced □ Significant Other □ Widow □

Height:_____Weight:_____Desired Weight:_____

Occupation:_____Employer:_____

Emergency Contact:_____Relationship:_____Phone:_____

Referred by:_____

Children: Name, Age, Living with you?_____

_____

Are you currently under a doctor's care?_____For what?_____
Current Practitioners:
Name:_____Address:_____Phone:_____
Yoga Therapy Treatment Goals: (physical, emotional, etc):
1) _____
2)_____
3)_____

Stressors in your life: (rate stress level 1-10, 10 the worst)
Family:_____Social:_____Work related:_____Stress in your body?_____Other?_____
Where do you hold tension?_____
Do you exercise? Yes □ No □ What?_____How often?_____How long?_____
Energy level and pattern?(least and most productive time of the day)_____

Are you pregnant?_____Due date:_____
Serious past Illnesses?_____
Accidents, Injuries and dates?_____
Hospitalizations and dates?_____
Current prescription medications?_____

Current herbs and supplements?_____

PERSONAL HEALTH HISTORY

Current Medical Concerns:

□ Asthma
□ Blood Clots
□ Breast Lumps
□ Cancer
□ Chronic Fatigue
□ Diabetes
□ Epilepsy
□ Headaches
□ Heart Problems
□ Hemophilia
□ HIV
□ Infections
□ Liver Problems
□ Lupus
□ Multiple Sclerosis
□ Osteoarthritis
□ Osteoporosis
□ Rheumatoid Arthritis
□ Stomach Ulcers
□ Allergies/Sensitivities
□ Other:_____

Symptom Survey
Check and fill if applicable

General

□ General Fatigue
□ Loss or excessive gain in weight
□ Average hours of sleep per night
□ Quality of sleep: good, fair. poor
□ Insomnia
□ Motion sickness
Other_____

Urinary

□ Frequent urination
□ Involuntary escape of urine
□ Burning/discharge
□ Weak urine stream
□ Frequent urinary track infection
□ Bedwetting
□ Constant urge to urinate
□ Flank pain

Respiratory

□ **S**inus problems
□ Difficulty breathing deeply
□ Nosebleeds
□ Frequent coughing
□ Frequent cold/sore throat
Other_____

Senses

□ Glasses/contact lenses
□ Eyesight worsening
□ Hearing difficulties
□ Earaches
□ Ringing in ears
□ Dizzy/loss of balance
Other:_____

Cardiovascular

□ Rapid or skipped beats
□ Varicose veins
□ Bruise easily
□ Chest pain
□ Cold hands/feet
□ Shortness of breath with activity
□ High blood pressure
Other:_____

Digestive

□ Frequent indigestion
□ Heartburn
□ Gas/bloating
□ Nausea/vomiting
□ Abdominal cramps
□ Frequency of bowel
□ Constipation/diarrhea
□ Pain/itching in rectum
□ Hemorrhoids
□ Excessive or loss of appetite

PERSONAL HEALTH HISTORY

Neuromuscular:

□ Headaches
□ Muscle pain. Where?_____
□ Muscle cramping
□ Weakness in arms and legs
□ Swollen joints
□ Frequent dislocations
□ Jaw/pain-tension (TMJ)
□ Frequent bone fracture
□ Memory loss
□ Absent minded
□ Numbness/tingling
Where?_____
Other:_____

Endocrine

□ Swollen Glands
□ Excessive thirst, hunger, sweat
□ Slow/fast metabolism
□ Blood sugar imbalance
□ Thyroid problem – low energy
Other:_____

Skin

□ Skin eruptions
□ Excessive sweating
□ Dry and oily skin
□ Hair loss
Other:_____

Men

□ Burning/discharge urination
□ Lumps/swelling of testicles
□ Pain in prostate or testicles
□ Sores on penis or scrotum
□ Hernia

Cancellation Policy:

So that I may better serve my clients, 24hrs notice is required for cancellation. You will be charged the full session with less than 24hrs notification.

Disclaimer:

1. I understand that this work does not constitute nor is a substitute for medical treatment., but rather is a form of health maintenance. I realize that this therapist is not a doctor and does not diagnose, prescribe or treat any specific conditions.

2. I understand and agree that I am responsible for keeping my therapist informed of any changes in my physical condition as this could affect the treatment I receive.

Signature:_____Date:_____