**Confidential Health Background**

**AUM hOMe Shala Yoga Therapy**

**Personal Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday: \_\_\_\_\_\_\_\_\_\_\_\_\_

Daytime Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evening Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The following confidential information will** b**e used to plan safe and effective yoga therapy sessions. Please answer the questions to the** b**est of your knowledge.**

**Reaso**n **for your visit**

What is your primary issue? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you experience your symptoms?

Constantly (76-100% of the time) Frequently (50-75%) Occasionally (26-50%) Intermittently (up to 25%)

When did you first notice it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you know what brought it on? \_\_\_\_\_\_\_\_\_

What activities provide relief? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes it worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How are your symptoms changing with time? (circle one)

Getting Worse Staying the same Getting better

Have you tried ay other therapies or treatments? *(Y/N)*

*If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Describe your sleep recently: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you hope to accomplish? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_ Body Awareness

\_\_\_ Muscle Strengthening \_\_\_ Muscle Stretching and Flexibility

\_\_\_ Improve Other Body Systems: \_\_\_ Stabilization of Joints

\_\_\_ Diet and Lifestyle \_\_\_ Pain Reduction

\_\_\_ Digestion and Elimination \_\_\_ Overall Posture Improvement

\_\_\_ Specific Yoga Postures or Practices \_\_\_ Improve Breathing

\_\_\_ Improve Energy Level \_\_\_ Improve Sleep

\_\_\_ Breath Awareness \_\_\_ Overall Stress Reduction

\_\_\_ Less Trouble Handling Emotions \_\_\_ Less Reactive/Upsetting

\_\_\_ Less Anxiety or Depression \_\_\_ More Satisfying Personal Relationships

\_\_\_ Finding Greater Fulfillment at Work \_\_\_ Greater Sense of Self-esteem

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

How much time per day can you devote to doing yoga or healing work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health History**

Are you currently under a physician’s care for an acute or chronic issue? *(Y/N)*

*If yes, please explain* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last Physical Exam: \_\_\_\_\_\_\_\_\_

What do you do for relaxation/exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise regularly and/or participate in any sport? *(Y/N)*

*If yes, which sport*? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you recently suffered an injury? *(Y/N)*

*If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Are you *uncomfortable* with any of the following areas:

*Gluteal Region (Y/N) Pectoral Region (Y/N) Face/Scalp (Y/N) Feet (Y/N)*

Please list any medications (vitamins, herbs or pharmaceutical) you are currently taking or at regular intervals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any injuries/accidents/illnesses or surgeries still affecting you and how you have been caring for them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience stress in your work, family or other aspects of your life?

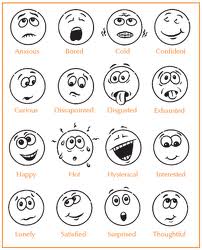
(Circle the one that best describes)



And how you believe it affects your health:

Muscle tension Anxiety Insomnia Irritability Digestive Disturbances

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

Circle the face or faces that best describes how you are feeling 

Using the symbols below, please identify the areas of concern on the chart below:

/// (sharp pain) xxx (burning , radiating pain) ~~~~ (numbness) 000 (dull ache)



**Health History**

*Please indicate any Present (P), Past (X), or Reoccurring (C) conditions:*

\_\_\_\_ ADD/ADHD \_\_\_\_Metal implants / artificial joints

\_\_\_\_ Allergies \_\_\_\_ Mononucleosis

\_\_\_\_ Alzheimer’s disease \_\_\_\_ Multiple Sclerosis

\_\_\_\_ Anxiety disorder what stage? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Arthritis \_\_\_\_ Muscular Dystrophy

\_\_\_\_ Athletes foot \_\_\_\_ Numbness/ Tingling

\_\_\_\_ Asthma \_\_\_\_ Osteoporosis/Osteopenia

\_\_\_\_ Blood Clot/ Deep Vein Thrombosis/ \_\_\_\_Osteoarthritis

Phlebitis/ Embolism \_\_\_\_ Pain

\_\_\_\_ Broken or fractured bones \_\_\_\_ Rheumatoid Arthritis \_\_\_\_ Bursitis -Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Cancer --Muscular or Joint: \_\_\_\_\_\_\_\_\_\_\_\_\_

--Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ -- Chronic? Y/N

--Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Paralysis

-- In Remission? Y/N \_\_\_\_ Parkinson’s disease

\_\_\_\_ Carpal Tunnel Syndrome \_\_\_\_ Pregnancy

\_\_\_\_ Cerebral Palsy \_\_\_\_ Psoriasis

\_\_\_\_ Chronic Fatigue Syndrome \_\_\_\_ Rash

\_\_\_\_ Contagious condition \_\_\_\_ Sciatica

\_\_\_\_ Crohn’s disease \_\_\_\_ Scoliosis

\_\_\_\_ Depression \_\_\_\_ Seizure

\_\_\_\_ Diabetes \_\_\_\_ Sleeping problems

\_\_\_\_ Type I \_\_\_\_ Type II \_\_\_\_ Spasms/ Cramping

\_\_\_\_ Diverticulitis \_\_\_\_ Strain/ Sprain

\_\_\_\_ Eczema \_\_\_\_ Stroke

\_\_\_\_ Epilepsy \_\_\_\_ Tendonitis

\_\_\_\_ Epstein Barr \_\_\_\_ Thyroid issues

\_\_\_\_ Fertility Concerns \_\_\_\_ TMJ/ Jaw Pain

\_\_\_\_ Fibromyalgia \_\_\_\_ Tumor

\_\_\_\_ General Fatigue --Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Gout --Malignant or Benign? \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Headaches \_\_\_\_ Varicose Veins

--Type: \_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Vertigo, dizziness or loss of balance

\_\_\_\_ Hearing Impairment \_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Heart Condition

\_\_\_\_ Herpes/ Shingles

\_\_\_\_ High/ Low Blood Pressure

\_\_\_\_ High/ Low Cholesterol

\_\_\_\_ HIV/AIDS

\_\_\_\_ Lupus

\_\_\_\_ Lymph edema