# Yoga Therapy
## Intake & Health History Form

BODY COLLECTIVE
BREATHE • MOVE • CONNECT

## GENERAL INFORMATION

Date: _____

Name: _____ Birth Date: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ E-mail: _____

Place of Birth: _____ Height: _____ Weight: _____ Age: _____

Gender: _____ Preferred Pronoun (he/she/they, etc.): _____

Occupation: _____ Family Physician: _____

Referred by: _____

Emergency Contact (name & phone): _____

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Have you ever received Yoga Therapy before? ☐ Yes ☐ No

If yes, when was your last yoga therapy session? _____

_____

Tell us about the reasons why you are seeking yoga therapy. Do you have a specific goal that you would like to work toward with your yoga therapist? _____

_____

_____

How long ago did this begin? _____

Have you received any treatment for this? If yes, please describe (including any supplements or medications you are currently taking to address this issue) _____

_____

_____

To what extent has this impacted your daily life? _____

_____

How much time (each day/week/month) are you willing to devote to your home yoga practice?

_____

_____

# HEALTH HISTORY

**Past Medical History** *(please check all that apply)*

- ☐ Cancer
- ☐ Arthritis
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Breathing Problems
- ☐ High Cholesterol
- ☐ Hepatitis
- ☐ Heart disease
- ☐ Venereal Disease
- ☐ Alcoholism
- ☐ Emotional Disorders
- ☐ Seizures
- ☐ Depression or Anxiety
- ☐ Thyroid Disease
- ☐ Digestive Disorders
- ☐ Other

_____

_____

**Surgeries or Hospitalization**

Significant Trauma: _____

Allergies (drugs, chemicals, foods): _____

_____

Birth History (ie prolonged labor, forceps delivery): _____

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**Occupation**

Occupational Stress *(chemical, physical, psychological)* _____

_____

Do you have a regular exercise program? *(please describe)* _____

_____

_____

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**Medicines**

Please list all medicines taken in the last two months *(include vitamins, over the counter drugs, herbs, etc.)* _____

_____

_____

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**Diet and Nutrition**

Are you or have you ever been on a restricted diet? What kind? _____

_____

Please describe your average daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snack: _____

How many cigarettes do you smoke per day? _____

How much coffee, tea, or soda do you drink per week? _____

Please describe any use of drugs for non-medical purposes: _____

_____

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**Please describe any areas of your body that are painful or distressed:** _____

_____

_____

_____

_____

_____

_____

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## RECENT HEALTH HISTORY

**Have you experienced the following within the last 3 months?** (Select all that apply)

**General**

- ☐ Night sweats
- ☐ Sweat easily
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Change in appetite
- ☐ Poor appetite
- ☐ Unusual tastes
- ☐ Cavings
- ☐ Desire hot/cold food
- ☐ Strong thirst hot/cold
- ☐ Weight loss/gain
- ☐ Bleeding or bruising easily
- ☐ Poor balance
- ☐ Tremors
- ☐ Local weakness
- ☐ Sudden energy drop (what time of day?) _____

**Skin and Hair**

- ☐ Rashes
- ☐ Itching
- ☐ Pimples
- ☐ Acne
- ☐ Hives
- ☐ Eczema
- ☐ Loss of Hair
- ☐ Ulcerations
- ☐ Dandruff
- ☐ Dry skin
- ☐ Recent moles
- ☐ Any other hair or skin changes/problems? _____

**Head, Eyes, Ears, Nose, Throat**

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glasses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Eye pain
- ☐ Eye strain
- ☐ Night blindness
- ☐ Color blindness
- ☐ Blurred vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Spots in front of eyes
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Recurrent sore throat
- ☐ Grinding teeth
- ☐ Facial pain
- ☐ Teeth Problems
- ☐ Jaw clicks
- ☐ Sores on lips or tongue
- ☐ Headaches (where?) _____
- ☐ Other head or neck problems? _____

**Cardiovascular**

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heartbeat
- ☐ Blood clots
- ☐ Dizziness
- ☐ Swelling of hands
- ☐ Chest pain
- ☐ Fainting
- ☐ Swelling of feet
- ☐ Difficulty breathing
- ☐ Cold hands or feet

**Respiratory**

- ☐ Cough
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Asthma
- ☐ Phlegm (what color?) _____
- ☐ Pain with deep breath
- ☐ Chest pain
- ☐ Wheezing
- ☐ Bronchitis - Difficulty breathing while lying down? ☐ Yes ☐ No

**Gastrointestinal**

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Burping/Belching
- ☐ Black stools
- ☐ Blood in stools
- ☐ Indigestion
- ☐ Bad breath
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use
- ☐ Parasites
- ☐ Other problems? _____

**Bowel movements**

Frequency: _____ Color: _____ Texture/Form: _____

Strong odor: ☐ Yes ☐ No

**Genitourinary**

- ☐ Pain or discomfort when urinating
- ☐ Urgency to urinate
- ☐ Decrease in flow
- ☐ Frequent urination
- ☐ Urine incontinence
- ☐ Color of urine?
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Impotency
- ☐ Sores on genitals
- ☐ Do you wake to urinate? If yes, how often? _____

**Psychological/Neurological**

- ☐ Depression
- ☐ Concussion
- ☐ Anxiety
- ☐ Stress
- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ General Anxiety Disorder (GAD)
- ☐ Bipolar
- ☐ Seizures
- ☐ Irritability
- ☐ Numbness
- ☐ Lack of coordination
- ☐ Loss of balance

Have you or do you currently struggle with emotional fluctuations that reduce your quality of life? If yes, please explain. _____

_____

_____

Have you ever attempted suicide? ☐ Yes ☐ No

Are you currently experiencing or have you previously experienced any other psychological or neurological problems? ☐ Yes ☐ No. If yes, please describe. _____

_____

_____

**Gynecology and Pregnancy**

Number of Pregnancies _____
Number of Births _____
Number of Miscarriages _____
Number of Abortions _____
Premature Births _____

Age of first menses _____
Days between periods _____
Duration of period _____
First day of last period _____
Last PAP _____

- ☐ Breast lumps
- ☐ Atypical vaginal discharge
- ☐ Breast tenderness
- ☐ Pelvic infections
- ☐ Infertility
- ☐ Hot flashes
- ☐ Fibroids
- ☐ Endometriosis
- ☐ Ovarian cysts
- ☐ Painful period
- ☐ Irregular periods
- ☐ Clots
- ☐ Unusual periods ☐ Heavy ☐ Light
- ☐ Birth control use? (Type, how long?) _____

**Lifestyle**

Briefly Describe Your Daily Routine. How Much Time Do You Spend Sitting, Driving, Standing, At A Desk, Lifting Heavy Objects, Or Lying Down? _____

Describe Your Daily Sleeping/Waking Habits. When Do You Go To Sleep? When Do You Wake Up? Do You Sleep With Anyone Or With Pets? Do You Feel Rested When Waking? _____

Describe You Overall Energy Level On A Scale Of 1 (Low) To 5 (High). Is Your Energy Constant Or Does It Fluctuate? When Do You Feel Most Energized And Least Energized? _____

What Types Of Situations Trigger Stress Or Bring It On For You? _____

If You Are In Pain, What Relieves Your Pain? What Increases Your Pain? _____

What Types Of Activities Do You Do For Fun? _____