|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Client name:** |  | | **Date of Birth:** | |  | |
| **Address Line 1** |  | | **Address line 2** | |  | |
| **Town** |  | | **Post code** | |  | |
| **Gender** |  | | **Marital Status** | |  | |
| **Mobile (or Main)** |  | | **Emergency contact** | |  | |
| **Occupation** |  | | **Email Address** | |  | |
| **Referred by** |  | | **Date of First  Appointment** | |  | |
| **Yoga Therapy** | | | | | | |
| What conditions are you interested in yoga therapy for? **Please list in order of priority importance to you**. | |  | | | | |
| Do you have previous yoga experience? | | Yes / No. If yes, please describe: | | | | |
| What benefits do you hope to get from yoga therapy? | |  | | | | |
| **Previous Treatment** | | | | | | |
| Have you seen, and are you currently seeing any practitioner(s) (including complementary practitioners)? | | Yes / No If yes, please describe: | | | | |
| Are you currently taking any medication, herbs or supplements? | | Yes / No If yes, please list by condition: | | | | |
| Have you had time off work for this condition? | | Yes / No If yes, please describe: | | | | |
| **Health Status – For multiple choice, please circle, bold, or delete as relevant** | | | | | | |
| **Height** | |  | | **Weight** | |  |
| **Energy level** | | Good / moderate / poor / erratic | | **Appetite** | | Good / moderate / poor / erratic |
| **Sleep Onset** | | Fast / takes time / erratic | | **Sleep Quality** | | Good / moderate / poor / erratic |
| **Bowel Movement** | | Regular / irritable / constipated / erratic | | **Menstruation** | | Normal / Menopause / Problematic (describe) |
| **Are you pregnant? /**  **Age(s) of children** | | Yes / No | | **Muscle / joint pain / stiffness** | | No / Yes (describe) |
| **Breathing** | | Asthma / Other (describe) | | **Heart / Circulation / Blood Pressure** | | High BP / Low BP / Arrhythmia /Heart Attack / Other: |
| **Nervous System** | | Stroke / Fainting / Dizziness / Numbness Pins & Needles /Other | | **Headaches (Give frequency)** | | Migraine / Tension / other |
| **Problems with eyes /ears /nose /mouth?** | | No / Yes (describe) | | **Skin problems** | | No / Yes (describe) |
| **Typical diet** | |  | | **Mealtimes** | | Regular / erratic / eat late in the evening |
| **Do you drink alcohol? How many units/week?** | | Yes / No | | **Do you smoke? How much?** | | Yes / No |
| **Do you drink caffeine? How much per day?** | |  | | **Exercise Type & frequency** | |  |
| **Family Medical History** | | | | | | |
| **Please list any chronic health conditions:** | | Mother: | | | | |
| Father: | | | | |
| Grandparent: | | | | |
| Sibling: | | | | |
| **Please list any previous or current events:** | | Surgeries: | | | | |
| Accidents/Injuries: | | | | |
| Illness: | | | | |
| **Mind & Emotions** Worry /anxiety / stress depression/ hyperactive irritable/other | |  | | | | |
| The above information is correct and complete and I am willing to provide further information in follow up sessions.  **Signed and date** | | | | | | |