YOGATHERAPYGREECE

CONFIDENTIAL HEALTH INFORMATION

Please complete and return this form at least 48 hours ahead of your first appointment either by hand or by email

Name				**Date of Birth**	
Gender		**Age**		**Relationship Status**	
Telephone	Mobile:			**No. & ages of children**	
Email Address				**Occupation**	

Please describe your **reasons** for coming for Yoga Therapy. **Please list in order of priority.**	
Please describe any previous yoga experience.	
Positive goals for the yoga therapy?	

Medical History

Do you have any numbness, pain, limitations in: (please check) **Neck -Shoulders-Wrists Elbows-Jaw- Upper Back- Lower Back-Sacrum- HipsKnees-Ankles-Feet**	Surgeries:
	Accidents/ Injuries:
Do you have any **Cardiorespiratory** Issues like High/Low Blood Pressure, Heart Attack, Asthma, COPD, other.	Please mention Symptoms, Diagnosis, Treatment
Do you have any **Digestive Disorder** conditions like IBS, Constipation, Bloating, Reflux, Indigestion, other.	Please mention Symptoms, Diagnosis, Treatment
Do you have any **Women's Health Issues** like Absent or Painful Menstruation, Menopause, Incontinence, other.	Please mention Symptoms, Diagnosis, Treatment
Do you have any other **Health Issue** like Cancer, Diabetes, Epilepsy, Stroke, Fibromyalgia, Headaches,	Please mention Symptoms, Diagnosis, Treatment

Migraines, other.			
Have you seen any **doctor** or other **health practitioner** for the problem(s)?	Describe Symptoms, Diagnosis, Treatment.		
Are you currently taking any **medication, herbs, supplements**? Please list with reasons.			
What is your prevailing **mood, emotional state?** Joy, Depression, Anxiety, Anger, other			
What makes you **feel better** Interests -hobbies- activities you most enjoy?			
Energy level: Good- poor -moderate-erratic		**Appetite:** Good – moderate- poor- erratic	
Bowel Movement: constipation/ frequent/ diarrhoea		**Sleep Quality:** Good- moderate - poor /erratic	
Typical diet & allergies:		**Mealtimes:** Regular - erratic - eat late in the evening	
Do you drink alcohol?	Yes / No Units per week	**Do you smoke?**	Yes / No No per day
Do you drink caffeine?	Yes / No Cups per day	**Exercise Types Frequency**	Hours per day/week
Family History			
Please list any chronic family health conditions:	Mother:		
	Father:		
	Grandparent:		
	Siblings:		

Signature -