moving from within

*This confidential information allows your instructor to understand your specific needs when you work together.*

Name: Date:

Address:

Telephone/s: E-mail:

Occupation:

Age:

MEDICAL HISTORY

1. Do you have or have you had:

_____ High Blood Pressure
_____ Glaucoma
_____ Osteoporosis
_____ Seizures
_____ Diabetes
_____ Rheumatoid Arthritis
_____ Anemia
_____ Heart problems
_____ Asthma
_____ Other breathing problems
_____ Dizziness, vertigo or loss of balance
_____ Unexplained falls or fractures
_____ Hearing difficulties
_____ Hernias or ruptures
_____ Major surgeries
_____ Back problems
_____ Epilepsy
_____ Arthritis
_____ Hypoglycemia
_____ Cancer
_____ Other

_____ Unstable joints
_____ Joint dislocation
_____ Metal implants/artificial joints
_____ Bladder or bowel problems
_____ Pinched nerves or disc problems
_____ Sciatica
_____ Broken bones
_____ Allergies
_____ Headaches
_____ Visual difficulties
_____ Chest pain
_____ Night sweats
_____ Joint swelling
_____ Traumatic accidents
_____ Other chronic conditions
_____ Joint problems
_____ Fibromyalgia
_____ Low blood pressure
_____ Chronic Fatigue
_____ Anxiety
_____ Depression

2. Do you experience pain in any part of your body - on occasion, acute or chronic?

3. Surgeries - include dates of treatment:

4. Women only:
___Hysterectomy?
___Menopause challenges?
___Menstruation?
___Pregnant? Yes No

5. Have you been under the care of a licensed health care professional in the past year? For what?

6. Medications & supplements you are currently taking:

7. Have you experienced other heath problems or challenges in your life?

8. This is very important
Please mention any other health or medical condition that you believe may be helpful to your instructor with regard to any precautions that should be taken to ensure your well-being.

LIFESTYLE

1. How would you describe your breathing?

2. Energy:

a) How would you describe your energy levels?

b) Is your overall energy stable or quite variable?

3. Body temperature

a) Do you generally run warm or cold? Please explain:

b) Do you prefer hot or cold weather?

4. Stress

a) How is your stress level?

b) What types of situations trigger stress or bring it on for you?

c) What are some of the ways you find most effective for releasing stress?

5. Do you awaken from sleep feeling rested?

6. What do you do to bring joy, peace, health and balance into your life?

7. How well do you feel you nourish yourself - with food, love and laughter?

8. How would you describe your state of mind most of the time?

9. How would you describe your spiritual or religious life?

YOGA HISTORY

1. What is your experience with Yoga, meditation or other spiritual practices?

2. How often do you practice and is your practice regular?

3. What have you found most beneficial from these practices?

4. What have you found most difficult or challenging?

5. Have you had any previous Yoga injuries? How did they happen?

6. What do you hope to get out of Yoga practice? What is your main goal for Yoga practice?

7. Do you have any other comments/concerns?

_____ _____

Signature Date