History and Lifestyle Inquiry Form

This form has been given to you by your yoga therapist to assist in better understanding your background and concerns. This will help in determining what practices will be best suited for you. Please take a few minutes complete this form to the best of your ability. Please use back of form if needed.

Name: _____ Profession: _____
Address: _____
Phone: Home _____ Work _____ Mobile _____
Marital Status: _____ No. of Children: _____Grandchildren _____
Name / Phone of Doctor _____
E-mail address_____-

☐ Yes, sign me up for the monthly e-newsletter

Living Situation (i.e. Nurturing loving situation / stressful place / argumentative place)

_____

_____

_____

Exercise Regime and/or Current Yoga Practice (if any) _____

_____

_____

_____

Main Health Problem / Concern: (Include symptoms, how long bothered, etc.) _____

_____

_____

_____

_____

_____

Other Health Problems (Please specify if past or present, dates occurred, etc.) _____

_____

_____

Medications and/or Complementary Therapies Currently Used: _____

_____

_____

_____

Serious Health Problems of Relatives: _____

_____

_____

Sleep Pattern: (Hours per night, number of times you wake, difficulties in getting sleep) _____

_____

How many times a day do you eat? _____

Dietary Habits (fast foods, carnivore, natural foods, vegetarian, vegan, etc…)
& Types of food in diet (meat, vegetables, fruit, carbohydrates, sweets, cakes, etc)**:**

_____

_____

_____

_____

_____

_____

Do you have time to cook fresh produce or do you buy prepackaged food? _____

_____

_____

How often do you eat out / get take outs? _____

_____

_____

What type of beverages do you drink? (Tea/coffee/soft drinks/water/alcohol) _____

_____

_____

How Much Do You Drink a Day? Water: _____Other: _____

What would you like to achieve from Yoga Therapy? Please list up to three goals.

_____

_____

_____

_____

Any other information? _____