Individual Yoga Therapy
History and Lifestyle Inquiry Form

This form has been given to you 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 to complete this form to the best of your ability. Please use back of form if needed.

Name: _____Birthdate: _____
Address: _____
Phone: Home _____ Mobile _____
Email: _____
Preferred Mode of Contact – please circle one or more of the above
Marital Status: _____ No. of Children: _____Grandchildren _____
Job (previous, if retired):_____
How would you describe your work environment (if applicable)?_____

Main Health Problem / Concern:

When did symptoms begin?

Suddenly/gradually?

Duration/frequency?

Character?

What makes it worse?

What makes it better?

What's causing problem from your perspective?

How does your main health problem impact:

Your daily activities?

Your rest/sleep?

Your mood?

Your work?

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

_____

_____

Medications and/or Complementary Therapies Currently Used and their effectiveness:

_____

_____

_____

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

Current level of energy?

Current level of stress?

Dietary Habits (fast foods, carnivore, natural foods, vegetarian, vegan, prepackaged foods, etc…)

What types of beverages do you drink and how much do you drink a day?

How would you describe your:

a)Living Situation? (i.e. Nurturing/ loving / stressful / argumentative)

b)Activity level?

c)Temperament?

d)Sources of joy in your life?

Current exercise regime and or current yoga practice (if any)_____

_____

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

_____

_____

_____

What time do you realistically have daily/weekly to devote to your individual yoga program on a daily basis?