INITIAL YOGA THERAPY ASSESSMENT

Name: ____ Date of birth: _______________ Age: _____

Address: ____
street number and name city state ZIP code

Home phone: ______________________________ Cell phone: __________________________________

May we leave a message on these numbers?: ☐ Yes ☐ No

Would you like a reminder of your appointments? ☐ Yes ☐ No

If yes, do you prefer: ☐ Phone ☐ Text ☐ Email ___________________________________

To whom should bills be sent?: ____

Billing address, if different from above: ____

Emergency contact: ____________________ Relationship: _________________ Phone: ______________

Primary physician: _________________ Clinic: ____________________ Phone: _____________________

Please list any other health care practitioners (cardiologist, chiropractor, acupuncturist, etc.): __________
____
____
____

Health concerns

Priority	Concern	Onset (month/yr)	How often*	Severity*
1				
2				
3				
4				
5				

* How often: 1-constant, 2-daily, 3-one to five times/week, 4-occasional, x-occurred only once
** Severity: 1-prevents regular activity, 2-makes regular activities harder, 3-prevents occasional activities, 4-makes occasional activities harder, 5-mild symptoms

What are your goals for this visit?: ____
____
____
____

Please use this space to describe yourself: ____
____
____
____
____
____
____

Review of systems

Please check (X) if any of the following apply to you now, or in the past, and indicate how often:

Conditions	Currently	Past	Notes
Headaches			
Migraine			
Jaw/ TMJ problems			
Hearing Problems			
Sinus problems			
Stuffiness, congestion			
Teeth grinding			
Neck lumps			
Neck pain/ stiffness Whiplash injury			
Chest pain/ pressure			
Difficulty breathing			
Pain with breathing			
Chronic Cough			
Shortness of breath			
Joint Pain/ stiffness			
Joint heat/ redness			
Joint swelling			
Leg pain			
Cold hands/ feet			
Chronic fatigue/ tiredness			
Frequent colds			
Infections, chronic			
Heat/ cold intolerance			
Light headedness/ fainting			
Dizziness/ vertigo			
Numbness/ tingling			
Tremor			
Back pain			
Muscle pain			
Muscle spasms/ cramps			
Abdominal pain			
Diarrhea			
Constipation			
Belching/ burping			
Fatigue after eating			
Flatulence/ gassiness			
Heartburn/ acid reflux			
Anxiety, nervousness			
Poor memory			
Depression			
Difficulty concentrating			
Mood swings			
Tension, stress			
Inability to hold urine			

Female reproductive history

Menstrual Pain/ Cramps			
PMS			
Perimenopausal			
Menopausal			
Hot flashes			
Are you pregnant?			
Are you breastfeeding?			
Number of pregnancies			
Number of children			

Medical history

Condition	No	Yes	Explain
Arthritis/ Rheumatoid			
Arthritis/ Osteo			
Asthma			
Autoimmune Disease			
Cancer Type:			
Depression			
Anxiety			
Diabetes			
Eating Disorder			
Epilepsy/ Seizures			
Gastrointestinal Disorder			
Glaucoma/ Cataracts			
Gout			
Heat Disease			
High Blood Pressure (controlled)			
High blood pressure (uncontrolled)			
Lung disease			
Mental illness			
Muscular disease			
Neurological disorder			
Osteopenia			
Osteoporosis			
Pain, chronic			
Skeletal disorder			
Stroke			
Thyroid Disorder			
Urinary disorder			
Vascular disorder			

List of prescription medications:

Medication	Reason for taking	Dose/ Times per day	Year started	Side effects, if any

List of over-the-counter medications:

Medication	Reason for taking	Dose/ Times per day	Year started	Side effects, if any

List of herbs, supplements or vitamins:

Supplement	Reason for taking	Dose/ Times per day	Year started	Side effects, if any

Substance use history

How much caffeine (soda, coffee, strong tea) do you drink:
Each day?_________ each week? _______ None______

Do you have a history of alcohol or drug abuse? ☐ Yes ☐ No

Do you currently use: ☐ Alcohol ☐ Drugs (please list):____

Do you think that you have a substance abuse problem? ☐ Yes ☐ No

Do you smoke cigarettes regularly? ____

Does anyone in your family have problems with drugs/alcohol? ___________________________________

Use of complementary or alternative therapies:

Type	Never Tried	Use Currently	Not for Me	Interested In
Massage				
Chiropractic				
Nutrition/ dietary therapy				
Yoga therapy				
Chakra therapy				
Color therapy				
Gem therapy				
Sound therapy				
Biofeedback				
Chinese herbs				
Other herbs				
Acupuncture				
Acupressure				
Environmental/ analysis				
Aromatherapy				
Essential Oils				
Reiki				
Others:				

Pain

Are you currently in pain? Yes _______ No _________ (if no, skip the next 5 questions)

Rate your overall level of current pain/ discomfort by circling the appropriate spot. “10” represents the worst pain you have ever experienced and “0” represents freedom from pain/ discomfort.

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain

1. Where is your pain located? ____

2. How long have you had it? ____

3. What helps you feel better? ____

4. What makes it worse? ____

Energy

Rate your overall energy level at various time of the day by circling the appropriate spot on the line below

Morning

1 2 3 4 5 6 7 8 9 10
low energy high energy

Afternoon

1 2 3 4 5 6 7 8 9 10
low energy high energy

Evening

1 2 3 4 5 6 7 8 9 10
low energy high energy

Sleep

Do you wake up in the morning feeling rested? Yes No

Are you tired much of the day? Yes No

What time do you usually go to bed? ____

How many hours a night do you sleep? ____

Do you wake up in the middle of the night? Yes No

How often? ____

Do you nap during the day? Yes No

If yes, how long? ____

Has there been a recent change in your sleep pattern? Yes No

If yes, please describe: ____

Preventative Health

Do you participate in any physical activity or exercise? Example: walking, going to the gym, group exercise class, sports, etc.

Activity	Amount of time/ day or week

Do you do any type of flexibility exercise such as yoga or stretching? Yes No

Do you do any type of resistance or weight training? Yes No

Are you interested in being more physically active? Yes No

What types of physical activity would you like to be involved in?___________________________________

Nutrition History

Are you currently on a special diet? Yes No

If yes, describe: ____

Have you ever felt out of control of your eating habits? Yes No

Have you had struggles with eating disorders (overeating, binging, purging)? Yes No

Your current weight? _________lbs Your current height? _____ft ____ inches

In the last year, have you experienced significant weight loss or weight gain? Yes No

Dietary Intake Recall

List all of the food you have eaten in the last 24 hours including snacks and beverages:

	Food/ Beverage	Amount	How prepared	Where eaten	At what time?
Breakfast					
Lunch	**Food/ Beverage**	**Amount**	**How prepared**	**Where eaten**	**At what time?**
Dinner	**Food/ Beverage**	**Amount**	**How prepared**	**Where eaten**	**At what time?**
Snacks	**Food/ Beverage**	**Amount**	**How prepared?**	**Where eaten?**	**At what time?**

Is this a typical day for you? If not, how is it different? ____

Who usually prepares your meals? ____

Do you usually eat alone or with someone? ____

What percentage of meat, eggs, poultry, fruit and vegetables you eat are organic? ______%

Are there any types of foods that you crave?

Food	Why?

Are there any types of foods that you do not eat?

Food	Why?

Social History

Do you live with anyone? If so, who? Please include pets.

Name	Age	Relationship

With whom do you have the most significant relationships? ____

Closest? ____

Most problematic?____

With whom do you share your feelings?____

Who would you call for a favor?____

Do you belong to a community or group with similar interests?

____

____

What do you do with your time?

____

____

How much TV do you watch each day? ______ hours

Hoe much time do you spend on the telephone/cell phone? _______hours

How much time do you spend at your computer? _________ hours

How much time do you spend playing computer games? _________ hours

Where were you born? ____

Where have you lived? ____

Where have you traveled? ____

Where would you like to go? ____

What interests/ hobbies do you have? ____

What magazines do you read regularly? ____

What is the last book you read? ____

Do you do any volunteer work? If yes, describe.

____

Emotional/Spiritual Health

What are the major stressors in your life?
____
____

How would you rate your stress level in the past month?
Circle the appropriate spot on the line below:

1 2 3 4 5 6 7 8 9 10
Completely relaxed Extremely Stressed

What do you do to relax? ____

How would you rate your emotional state in the past month?

Circle the appropriate spot on the line below.

1 2 3 4 5 6 7 8 9 10
Very Sad Very happy

Have you been to a support program or therapist for emotional issues (depression, anxiety, anger, panic attacks…etc)? Yes No

Do you have any phobias? If yes, explain: ____

Please check the appropriate column:

	Over the past TWO weeks, how often have you:	None or little of the time	Some of the time	Most of the time	All of the time
1	Been feeling low in energy, slowed down?				
2	Been blaming yourself for things?				
3	Had poor appetite?				
4	Had difficulty falling asleep, staying asleep?				
5	Been feeling hopeless about the future?				
6	Been feeling blue?				
7	Had feelings of worthlessness?				
8	Thought about or wanted to commit suicide				
9	Had difficulty concentrating or making decisions?				
10	Been feeling no interest in things?				

Would you consider yourself to be more of a optimist or a pessimist?
Place an X in the appropriate spot on the line below.

Pessimist Optimist

List any important/ stressful anniversaries (i.e. births, deaths, accidents, events, losses, illnesses, etc.)
____
____

Are there any other significant traumas (emotional, physical, world events, etc.) that have affected you? Please explain.
____

Have you ever been evaluated for post-traumatic stress disorder or depression?
____

What are your sources of hope or strength when things are difficult?
____

Is religion or spirituality important to you? If yes, in what way(s)? ___________________

Relaxation Methods

Technique	Never Tried	Do regularly	Not for me	Interested In
Watch TV				
Progressive Muscle Relaxation				
Meditation				
Visualization/ Guided Imagery				
Hypnosis				
Breathing Exercises				
Yoga				
Tai Chi/ Chi Gong				
Massage/ Body work				
Biofeedback				
Other:				

Personal Life Questions:

1. What are you currently doing in your life that brings you peace, health, balance and/or nurtures your soul? ____
____
____
____

2. Where in your health, life and relationships (to self and others) do you experience a lack of freedom, balance and joy?____
____
____
____

3. What areas in your life are you most interested in bringing balance to? ___________________________

4. If you achieved a perfect state of health, which is balance between body, mind and soul, what would your life look like? How would you feel? What would you be doing? What would be different? Paint a picture of yourself, and please describe. ___________________________

5. What results do you want to produce in your physical body? ___________________________

6. What results do you want to produce in regard to your mental and emotional wellbeing? ___________

7. What do you want your spiritual life to look like? ___________________________

8. How can I best support you in achieving the health, vitality, and balance you want in your life?_______

9.What would you have to give up to have the results you want? ___________________________

10. Is there anything else about your health you want me to know? Please explain. ___________________

Thank you for your time in completing this inventory. All information will be kept confidential in your medical records and will not be released without your permission.