yoga therapy session

Consultation Form

Personal Information

First & Last Name:_____ ***Birth Date*** (mm/dd/yr): __/__/____

Preferred Pronoun(s): he / she / they / _____ ***Primary Phone #:*** _____

E-Mail:_____ ***How did you hear about us?***_____

Health Information (***please circle, highlight or type into the form all of your current symptoms***)

Primary reason(s) for seeking Yoga Therapy:

Have you been formally diagnosed with any conditions?

Muscles, Bones, Joints:
body pain: [jaw, neck, shoulder, arms, chest, abdomen, back, hips, tailbone, legs, knee, ankle, feet, muscle pain, bone pain] / TMJ / teeth grinding / scoliosis / stenosis / sciatica / muscle cramping / fasciitis / hernia / arthritis / artificial joint replacement / thoracic outlet / carpal tunnel / frozen shoulder / flat feet / drop foot /

Sensory Organs:
ear aches / ringing in ears / swollen glands / nasal obstruction / sleep apnea / persistent runny nose / nosebleeds / chronic sinus issues / excess phlegm / seasonal allergies / headaches (sinus, tension, migraines) / mouth sores / visual problems / cataracts / heavy perspiration / rash / itching / dryness / dandruff / acne / eczema / psoriasis / sudden hair loss / loss of taste or smell /

Heart, Lungs, Circulation:
shortness of breath / wheezing / chronic cough / bronchitis / asthma / emphysema / COPD / high BP / irregular heartbeat / heart attack / heart disease / heart murmur / heart palpitations / chest pain / varicose veins / DVT / swollen limbs / high cholesterol / cardiomyopathy / pacemaker / cardiovascular stroke / TIA / cystic fibrosis / low BP / fainting / cold hands or feet / anemia /

Digestion & Elimination:
acidity / heartburn / nausea / vomiting / indigestion / bloating / gas / burping / bad breath / celiac / diarrhea / rectal pain / diverticulitis / hemorrhoids / SIBO / IBS / IBD (Crohn's, colitis) / bloody stool / constipation /

Kidney, Bladder, Liver:
frequent urination / urgency to urinate / pain on urination / incontinence / blood in urine / gout / kidney stones / gall bladder stomes / bladder infection / UTI / kidney problems / liver problems / jaundice /

Reproductive, Endocrine:
prostrate issue / hormonal issue / cysts / fibroids / endometriosis / PCOS / PMS / hot flashes / irregular periods / heavy periods / clotting / yeast infection / osteoporosis / osteopenia / diabetes / hyperthyroid / hypothyroid / difficulty conceiving / decreased libido /

Immunity:
infection (hepatitis / HIV / AIDS / COVID) / lupus / cancer / fibromyalgia / chronic fatigue / rheumatoid arthritis /

Neurological:
concussion / vertigo / dizziness / loss of balance / epileptic seizures / tremors / restless legs / Parkinson's / Alzheimer's / dementia / poor memory / MS / ALS / Bell's Palsy / neurological stroke / numbness /

Psychological, Behavioural, Relational:
anxiety / excess stress / mood swings / crying / anger / excessive thinking / grief / negative self-talk / PTSD / physical abuse / suicidal thoughts / hallucinations / addiction (alcohol, drugs, electronics, sex) / recent weight gain / sudden change in appetite (high, low) / obesity / overeating / binge eating / undereating / sudden weight loss / fatigue / insomnia / depression / loneliness /

Any Other Symptoms:

List history of past Surgeries, Accidents, Injuries and Health Issues *(include dates):*

List all current Medications *(include name of medication, dosage, start date, and for what purpose):*

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If Applicable (*please circle, highlight or type into the form all which may apply*)

If Pregnant, _____ month(s) **If *Reproductive Organs have been changed or removed, date:*** _____

Menstrual Cycle: None ☐ / Regular ☐/ Irregular ☐ ***Period Duration***: _____ days
Menstrual pain: None ☐ / Mild ☐/ Intense ☐ ***Menstrual flow***: Light ☐/ Heavy ☐/ Clotting ☐

Is there a family history of: Heart disease ☐/ BP ☐/ Stroke ☐/ Cancer ☐/ Diabetes ☐/ Arthritis ☐/ Alzheimers ☐/ Parkinsons ☐/ Mental health conditions ☐/ Other _____

Diet and Lifestyle (*please circle, highlight or type into the form all which may apply*)

Daily Food Habits: _____ *meals* + _____ *snacks* ***Typical Meal times are***: _____
Any Persistent Food Cravings? _____
Please circle if you regularly (3+ times per week) consume any of the following?

Sugar or Sweeteners / Soda Drinks / Processed Foods / Fried Foods / MSG / Excess Salt / Vegetable Seed Oils / GMO Foods (corn, soy) / Milk / Yogurt / Cheese / Eggs / Red Meat / White Meat / Fish / Flour or Baked Goods or Gluten-products (Wheat, Bread, Pasta) / Rice / Non-Organic Fruits or Veggies / Citrus / Nuts or Seeds / Nightshade Veggies (Tomato, Potato, Eggplant, Peppers) /

Caffeine? Never ☐/ Rare ☐/ Often ☐/ Daily ☐ **Alcohol consumption?** Never ☐/ Rare ☐/ Often ☐/ Daily ☐
Smoking? Never ☐/ Tobacco ☐/ Vaping ☐/ Marijuana ☐ **Recreational Drugs?** Never ☐/ Rare ☐/ Often ☐/ Daily ☐

Do you take Supplements? No ☐/ Yes ☐ – including: _____

List any known Allergies: _____
List any known exposure to Toxins, Heavy Metals or Chemicals: _____

Avg. # of Bowel movements / week: _____ ***Any issues with loose Bowels?*** No ☐/ Sometimes ☐/ Frequently ☐

Usual Sleep Time is: *from* _____ *to* _____ ***Upon awakening, usually feel:*** Refreshed ☐ / Tired ☐
Do you experience sleep difficulties? No ☐/ Yes ☐ - difficulty falling asleep ☐/ difficulty staying asleep ☐/ repeatedly waking to use the toilet ☐/ taking sleep meds ☐/ using a sleep apparatus ☐/
Usual Energy levels: Low ☐ / Steady ☐ / Fluctuating ☐

Occupation: _____ ***Sedentary Job:*** No ☐/ Yes ☐ ***Enjoy Work?*** No ☐/ Yes ☐
Typical workday is: _____ hours ***Typical commute time is:*** _____ mins
Typical workday schedule: leave home at _____ am/pm, and arrive back home at _____ am/pm

Do you experience Headaches? No ☐/ Yes ☐ – if yes, describe the:
Frequency? _____ **Duration**? _____ **Intensity**? _____

Regular (3+ times per week) exercise activities include: ***Exercise hours per week:*** _____
_____

How do you relax? ***What brings you joy?*** ***Live alone?*** No ☐/ Yes ☐
_____ _____

Available Time to Practice each day: _____ mins, **I am able to practice in the**: Morning ☐/ Afternoon ☐/ Evening ☐

Informed Consent:
I hereby consent to the rendering of evaluations, treatments and/or services as communicated by the Yoga Therapist. My consent is voluntary and I intend this consent to cover the entire course of assessment and treatment commencing on the date indicated below. I understand that I may ask questions at any time regarding the assessment and treatment and that this consent may be withdrawn at any time.
Signature or Initials: _____ Date: _____