Yoga Therapy –
Health Information Questionnaire

andrea price yoga

Please complete and return this form 48 hours in advance of your first appointment by hand or via andrea.price@t-online.de

personal data

Client name	Date of Birth
Address Line 1	Address line 2
Town	Post code
Gender	Marital Status
Mobile (or Main)	Emergency contact
Occupation	Email Address
Referred by	Date of First Appointment
Gender	Marital Status

Yoga Therapy

What conditions are you interested in yoga therapy for?
Please list in order of priority importance to you.

Do you have previous yoga experience? If yes, please describe: ◯ No ◯ Yes

What benefits do you hope to get from yoga therapy?

Yoga Therapy –
Health Information Questionnaire

andrea price yoga

Previous Treatment

Have you seen, and are you currently seeing any practitioner(s) (including complementary practitioners)? If yes, please describe: ◯ No ◯ Yes

.....

.....

Are you currently taking any medication, herbs or supplements? If yes, please list by condition: ◯ No ◯ Yes

.....

.....

Have you had time off work for this condition? If yes, please describe: ◯ No ◯ Yes

.....

.....

Health Status

Tick and fill in as appropriate.

Height: .....

Weight: .....

Energy level

- ◯ good
- ◯ moderate
- ◯ poor
- ◯ erratic

Appetite

- ◯ good
- ◯ moderate
- ◯ poor
- ◯ erratic

Sleep Onset

- ◯ fast
- ◯ takes time
- ◯ erratic

Sleep Quality

- ◯ good
- ◯ moderate
- ◯ poor
- ◯ erratic

Bowel Movement

- ◯ Regular
- ◯ irritable
- ◯ constipated
- ◯ erratic

Menstruation

- ◯ Normal
- ◯ Menopause
- ◯ Problematic describe:

.....

Are you pregnant?

◯ No ◯ Yes

Age(s) of children

.....

Yoga Therapy –
Health Information Questionnaire

andrea price yoga

Health Status –

Tick and fill in as appropriate.

Muscle / joint pain / stiffness

- ◯ No
- ◯ Yes describe:

.....

Breathing

- ◯ Asthma
- ◯ Other describe:

.....

Heart / Circulation / Blood Pressure

- ◯ High BP
- ◯ Low BP
- ◯ Arrhythmia
- ◯ Heart Attack / Other:

.....

Nervous System

- ◯ Stroke
- ◯ Fainting
- ◯ Dizziness
- ◯ Numbness Pins & Needles / Other:

.....

Headaches (Give frequency)

- ◯ Migraine
- ◯ Tension / Other:

.....

Problems with eyes /ears /nose /mouth?

- ◯ No
- ◯ Yes describe:

.....

Skin problems

- ◯ No
- ◯ Yes describe:

.....

Mealtimes

- ◯ Regular
- ◯ erratic
- ◯ eat late in the evening

Typical diet

.....

.....

.....

Do you drink alcohol?

- ◯ No
- ◯ Yes / How many units/week?

.....

Do you smoke?

- ◯ No
- ◯ Yes / How much?

.....

Do you drink caffeine?

- ◯ No
- ◯ Yes / How much per day?

.....

Exercise Type & frequency

.....

Yoga Therapy –
Health Information Questionnaire

andrea price yoga

Family Medical History

Please list any chronic health conditions:

Mother:
.....

Father:
.....

Grandparent:
.....

Sibling:
.....

Please list any previous or current events:

Surgeries:
.....

Accidents/Injuries:
.....

Illness:
.....

Mind & Emotions

- ◯ Worry
- ◯ anxiety
- ◯ stress depression
- ◯ hyperactive irritable / other describe:

.....

.....

The above information is correct and complete and I am willing to provide further information in follow up sessions.

.....
Signed and date

Print