

Name: _____ Date of Birth: _____ MRN: _____

How would you like to be addressed? _____

Preferred Pronoun? _____

Email Address: _____

Would you like to be added to Integrative Medicine’s electronic newsletter email list? Yes: No:

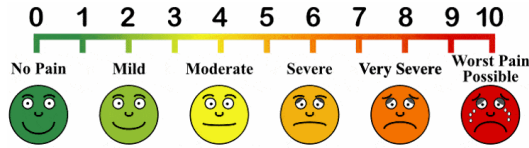
List your health goals and what you would like to achieve through yoga therapy:

Priority 1: _____ Priority 3: _____

Priority 2: _____ Priority 4: _____

Describe your current pain:

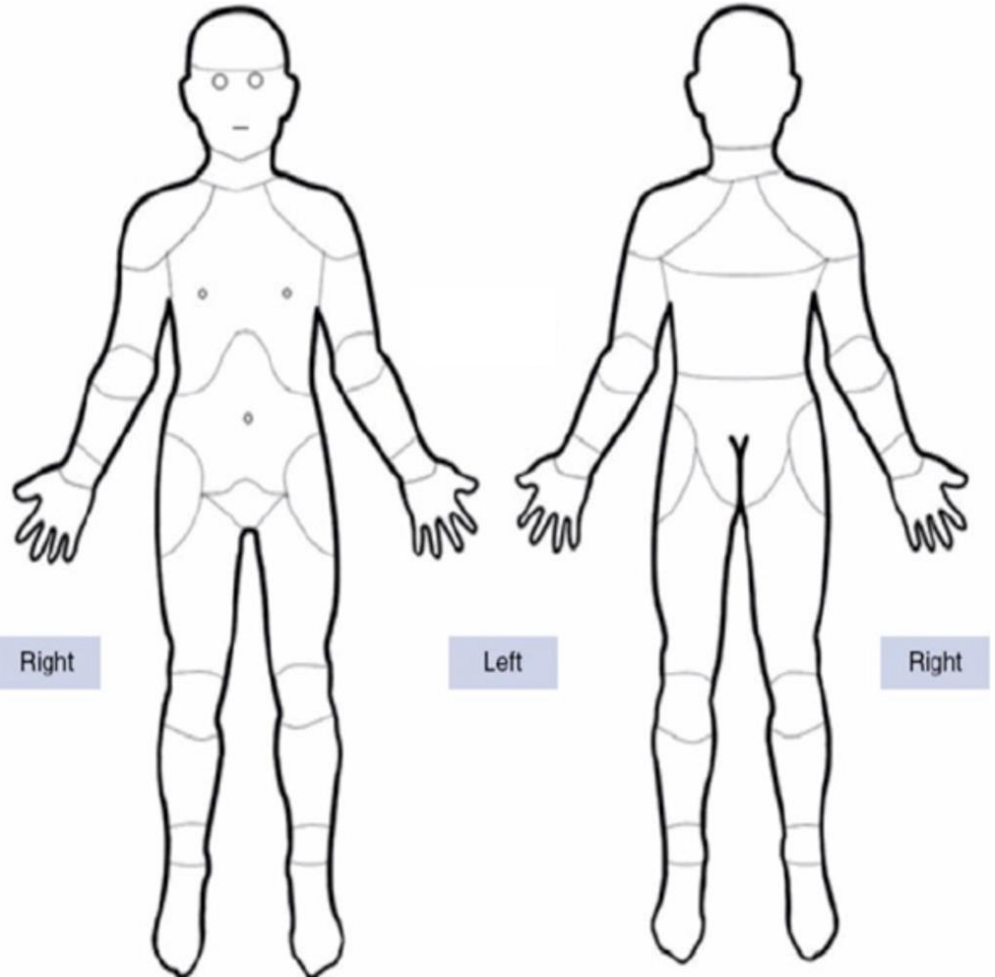
Circle your pain level on the scale.



Indicate any area of your body where you experience pain, tension, or stress:

What Decreases Your Pain

What Increases Your Pain



MRN: _____

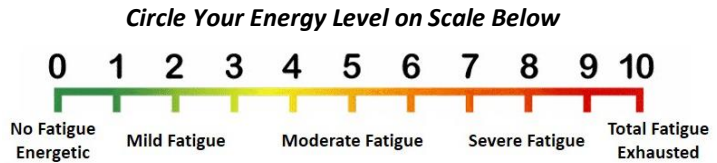
Current Stress Level



What causes you stress? _____

How do you manage stress? _____

Current Energy Level



How does your energy level change throughout the day? _____

Sleep

Number of hours per night? _____ During the night, how often do you wake up? _____

Refreshed upon waking? Yes: No:

Exercise

Do you exercise regularly? Yes: No:

Type of exercise: _____ Frequency: _____

Type of exercise: _____ Frequency: _____

Digestion/Nutrition

How often do you eat? _____ What snack food do you enjoy? _____

Do you have any food intolerance? Yes: No: Describe: _____

Describe your appetite: Always Hungry Regular Rarely Hungry

Do you have any discomfort after a meal? _____

Do you have any concern about the regularity of your bowel movements? _____

How much water do you drink per day? _____ How much caffeine do you consume per day? _____

MRN: _____

Medical History

Surgeries Location: _____ When: _____

Location: _____ When: _____

Injuries Location: _____ When: _____

Location: _____ When: _____

Use the back of this page if more room is needed:

Health Conditions

Do you have or have you had (please explain any Yes responses)?

Cardiovascular Disease: Yes: No: _____

Hypertension: Yes: No: _____

Cancer: Yes: No: _____

Diabetes: Yes: No: _____

Thyroid Dysfunctions: Yes: No: _____

G.I. Disorders: Yes: No: _____

Autoimmune Disorders: Yes: No: _____

Respiratory Problems: Yes: No: _____

Neurological Conditions: Yes: No: _____

Muscular Problems: Yes: No: _____

Mental Health Conditions: Yes: No: _____

Conditions of the Bones:
(osteoporosis, fractures) Yes: No: _____

Conditions of the Joints:
(osteoarthritis) Yes: No: _____

Women's / Men's Health
Diagnosis or Concerns: Yes: No: _____

Reproductive Health

What is your current reproductive health: Regular Periods Pregnant Menopause

Body Implants

Do you have a pacemaker, hearing aids, lumbar hardware, etc? _____

MRN: _____

Relationships

Are you in a supportive relationship? Yes: No: Do you have someone that you can confide in? Yes: No:

Employment

Are you currently employed? Yes: No: Occupation: _____

Miscellaneous

What do you do in your free time? _____

What is your idea of mind, body, spirit connection and how does it make you feel? _____

Overall, how satisfied are you with your life?



Unsatisfied

Somewhat Satisfied

Very Satisfied

Is there any other information you would like to share? _____

Please do not write below this line.

Practitioner Notes: _____
