

# Phoenix Rising Yoga Therapy Client History Form

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Ht. : \_\_\_\_\_ Wt. : \_\_\_\_\_

Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

E-mail: \_\_\_\_\_

Current Occupation: \_\_\_\_\_

Please list other body work modalities you have received (i.e. massage, shiatsu):

\_\_\_\_\_

Current exercise program: \_\_\_\_\_

\_\_\_\_\_

Experience in yoga and/or meditation: \_\_\_\_\_

\_\_\_\_\_

Briefly outline your personal support system (i.e. family, friends, health care providers, groups): \_\_\_\_\_

\_\_\_\_\_

What do you hope to receive from Phoenix Rising Yoga Therapy? \_\_\_\_\_

\_\_\_\_\_

Is there anything else you'd like me to know before we start our work? \_\_\_\_\_

\_\_\_\_\_

How did you hear about Phoenix Rising Yoga Therapy? \_\_\_\_\_

How did you hear about my practice in particular? \_\_\_\_\_

NOTE: The information requested on the following two pages, if you choose to provide it, will help me work more effectively with you.

Please fill in the following section for any condition for which you have been treated in the past two years that I should know about, including approximate dates and conditions.

General practitioner \_\_\_\_\_  
\_\_\_\_\_

Psychotherapist \_\_\_\_\_  
\_\_\_\_\_

Chiropractor \_\_\_\_\_  
\_\_\_\_\_

Psychiatrist \_\_\_\_\_  
\_\_\_\_\_

Homeopathic or  
Naturopathic Physician \_\_\_\_\_  
\_\_\_\_\_

Other (please list) \_\_\_\_\_  
\_\_\_\_\_

Please list below any prescription or non-prescription medication you are taking:

\_\_\_\_\_  
\_\_\_\_\_

Please list any history of surgeries, major illnesses, chronic conditions, accidents, injuries or anything that might be relevant to doing Phoenix Rising Yoga Therapy which were not listed on the previous page:

\_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_

Please check any condition that applies to you:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Addiction Recovery        | <input type="checkbox"/> Eating disorder                      | <input type="checkbox"/> History of Sexual Abuse             |
| <input type="checkbox"/> AIDS                      | <input type="checkbox"/> Emphysema or other breathing problem | <input type="checkbox"/> Low blood pressure                  |
| <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Fibromyalgia                         | <input type="checkbox"/> Menopause                           |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Fatigue                              | <input type="checkbox"/> Multiple sclerosis                  |
| <input type="checkbox"/> Bulging or herniated disc | <input type="checkbox"/> Fused vertebrae                      | <input type="checkbox"/> Osteoporosis                        |
| <input type="checkbox"/> Chronic Fatigue Syndrome  | <input type="checkbox"/> Heart Condition                      | <input type="checkbox"/> Pregnancy:<br>How many months? ____ |
| <input type="checkbox"/> Contact lenses            | <input type="checkbox"/> Hernia                               |  |
| <input type="checkbox"/> Degenerative disc disease | <input type="checkbox"/> High blood pressure: Type ____       |  |
| <input type="checkbox"/> Depression                | <input type="checkbox"/> Hepatitis: Type ____                 |  |