PHOENIX RISING YOGA THERAPY CLIENT HISTORY FORM

Today's date: ______________

Name ____ Age ___

Address____

Phone (Home) _______________________________________(Work)____________________________

Current Occupation ____

1. Please list the type and approximate date(s) of any other body work modalities you have received (i.e. massage, shiatsu, acupuncture):

____

____

____

2. Current exercise program:____

____

____

3. Experience in yoga and/or meditation: ____

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____

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

____

____

5. What do you hope to receive from Phoenix Rising Yoga Therapy? ____________________________

____

____

6. Is there anything else you'd like me to know before we start our work? _______________________

____

____

7. How did you hear about Phoenix Rising Yoga Therapy? ___________________________________

____

8. 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 to work more effectively with you.

Health Care Provider	Dates of Treatment (approx.)	Condition

Allopathic Physician ____________________

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____

____

Psychotherapist ____________________

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Chiropractor ____________________

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Psychiatrist ____________________

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____

Homeopathic or Naturopathic Physician ____________________

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9. Please list below any prescription or non-prescription medication you're taking:

____

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10. Please list any history of surgeries, major illness, 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____________________

11. Please check any condition which applies to you:

__________ Addiction Recovery: Length of time (days, months, years) in recovery: ________________

________ AIDS

________ Arthritis

________ Asthma

________ Bulging or herniated disc

________ Chronic Fatigue Syndrome

_________ Contact lenses (check only if you are wearing them now)

________ Degenerative disc disease

________ Depression

________ Eating disorder

________ Emphysema or other breathing problem

________ Fibromyalgia

________ Fatigue

________ Fused vertebrae

Heart condition

________ Hernia

_________ High blood pressure: Do you take medication? ______________________________

_________ History of physical, sexual, and/or emotional abuse

________ Low blood pressure

________ Menopause

________ Multiple sclerosis

________ Osteoporosis

________ Pregnancy: How many months? ______________