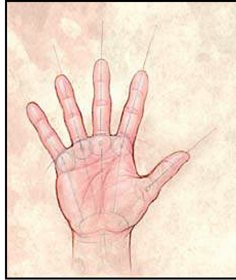
ART THERAPY CLINIC IYENGAR YOGA HISTORY HEALTH FORM



Your answers on this form will help your yoga practitioner to better understand your medical concerns and conditions before starting Yoga. This form is to ascertain any medical information that might be pertinent to your treatment and will be placed into your file. If you are uncomfortable with any questions, you need not answer it. If you cannot recall specific details, please provide your best guess. Thank you!

Name____

Age________ **DOB** ____________________

How would you rate your general health?
❑ Excellent ❑ Good ❑ Fair ❑ Poor
Main Reason for Today's participation in Yoga _____________
Have you ever practiced Yoga and if so, for how long?_____________
Have you ever practiced meditation and if so, how long?____________
Other Concerns____
____

Review of Symptoms: Please circle all that apply:

Constitutional
Recent Fevers/ sweats
Unexplained weight loss
Unexplained fatigue
Weakness

Eyes
Change in Vision

Ears/Nose/Throat/Mouth
Difficulty hearing
Ringing in ears
Hay fever/allergies
Congestion
Difficulty swallowing

Cardiovascular
Chest Pains/ discomfort
Palpitations
Short of breath

Breast
Breast lump
Nipple discharge

Respiratory
Cough/ wheeze
Coughing up blood

Gastrointestinal
Heartburn/ reflux
Blood in bowel movement
Nausea/ vomiting
Diarrhea
Pain in abdomen

Genitourinary
Painful/bloody urination
Leaking urine
Nighttime urination
Discharge- penis/vagina
vaginal bleeding
Concern w/ sexual functions

Musculoskeletal
Muscle/joint pain
Recent back pain

Skin
New or mole change
Rash

Neurological

Headaches Memory Loss Fainting *Psychiatric* Anxiety/ Stress Sleep Problem	 *Blood/Lymphatic* Unexplained lumps Easy bruising or bleeding *Endo*	Cold/ heat intolerance Increased thirst/appetite

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? ❑Yes ❑No ❑Sometimes

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, herbal supplements, birth control pills, ayurvedic prescriptions, etc.

Medication	Dose (e.g. mg/pill)	How many times per day?

Allergies or reactions to medications____

PERSONAL MEDICAL HISTORY:

Heart disease Specify type____________ Asthma/ Lung disease High Blood Pressure	Diabetes Other (specify)_________ High Cholesterol	Thyroid Problems Kidney Disease Cancer (specify) ___________________

SURGICAL HISTORY: Please list all prior operations (with dates):

____

____

____

____

FAMILY HISTORY: Please indicate the current status of your immediate family members: please indicate family members (parent, sibling, grandparent, aunt or uncle with any of the following conditions:

Alcoholism

____

Cancer, Specify type______________________

Heart Disease____________________________

Depression/Suicide__________________
______

Genetic Disorders_________________________

Diabetes____________________________

High Cholesterol____________________

High Blood Pressure________________

Stroke_____________________________

Bleeding or Clot Disorder___________________

Asthma_____________________________

Other Concerns_____________________

SOCIAL HISTORY

Tobacco Use:

Cigarettes ❑ Never ❑ Quit Date
❑ Current Smoker
packs/ day_____ # of years______
Other Tobacco ❑ Pipe ❑Cigar
❑Snuff ❑Chew
Are you interested in quitting? ❑Yes ❑ No

ALCOHOL USE:
Do you drink alcohol? ❑No ❑Yes
drink per week______________________
Is your alcohol use a concern for you or others?
❑No ❑Yes

DRUG USE:
Do you use any recreational drugs?
❑No ❑Yes
Have you ever used needles to inject drugs?
❑No ❑Yes

SEXUAL ACITIVITY:
Sexually active ❑No ❑Yes ❑Not currently
Current Sex partner is/ are ❑Male ❑Female
Birth Control method_____❑None needed

Have you ever had any sexually transmitted diseases (STD's)?
❑No ❑Yes

OTHER CONCERNS:
Caffeine Intake ❑None ❑Coffee, Tea, Soda ____ Cups/day

Weight: Are you satisfied with your weight? ❑No ❑Yes

Diet: How do you rate your diet? ❑ Excellent ❑ Good ❑Fair ❑Poor
Do you eat or drink four servings of dairy or soy supplements or take calcium supplements? ❑No ❑Yes

Exercise: Do you exercise daily?
What kind of exercise? ❑No ❑Yes
How long (minutes)? _________
How often?___________________________
If you do not exercise, why?_____________

Safety:
If you bike, do you use a helmet? ❑No ❑Yes
Do you use seatbelts consistently? ❑No ❑Yes
Is violence at home a concern for you?
❑No ❑Yes

Have you ever been abused? ❑No ❑Yes
Do you have a gun in your home? ❑No ❑Yes

Have you completed a living will or durable power of attorney for health care?

SOCIOECONOMICS HISTORY:
Occupation_______________________ Employer_____________________________
Years of highest degree__________ Marital Status: Single Partner/Married Divorced Widowed Other _________________
Spouse /Partner's Name________________ Number of Children_______________
Who lives at home with you?____

WOMEN'S HEALTH HISTORY:
# of pregnancies__________________ # deliveries___________ # abortions_________
miscarriages________________ Age at start of periods: _____________
Age at end of Periods______

Any additional comments:
____

____

I am aware that the instructor of Iyengar Yoga is here to serve me by sharing knowledge of yoga and health. I understand that the practice of yoga involves physical movement and exercise which may from time to time be strenuous, and that such practice carries some risk of injury. I also understand that I must judge my own capabilities with respect to practicing yoga with any instructor. By my participating in classes, I agree to take full responsibility for not exceeding my limits in the practice of yoga and for any injury I may incur in the practice of yoga. I acknowledge that it is my responsibility to inform Dr. Horovitz immediately if an injury occurs during class. I understand that, from time to time during classes with the instructor, she may physically adjust students' form when making a yoga posture. If I do not want such physical adjustments, I will so inform the instructor. I also acknowledge that if I do not wish to receive physical adjustments, it is my responsibility to inform the instructor when an adjustment has gone as far as I desire at that time. I hereby waive and release any claim that I might have at any time for injury of any sort against the Dr. Horovitz.

I have carefully read, fully understand, and agree to all the above.

________________________________ ____________________
Signature Date