



Health History

Check all that apply

Muscular-Skeletal

- Headaches
- Arthritis
- Joint Stiffness
- Spasms/cramps
- Strains/sprains
- Broken bones
- Tendonitis/bursitis
- Osteoporosis
- Scoliosis
- Back/hip pain
- Neck/Shoulder pain
- Jaw pain
- Arm/hand pain
- Leg/foot pain

Nervous System

- Numbness/tingling
- Chronic pain
- Fatigue
- Paralysis
- Cerebral Palsy
- Epilepsy
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's disease
- Spinal cord injury
- Seizures

Circulatory/Respiratory

- Dizziness
- Edema
- Varicose Veins
- Blood clots
- High blood pressure
- Low blood pressure
- Heart condition
- Stroke
- Allergies
- Sinus problems
- Asthma

Other

Skin

- Rashes
- Allergies
- Sores/wounds
- Acne
- Athlete's foot

- Hearing impaired / Visually impaired
- Thyroid Issues
- Diabetes
- Mental health conditions _____
- Pregnancy (indicate trimester) _____
- Cancer _____
- Infectious diseases _____
- Surgeries / Accidents _____
- Other _____

Are you under the care of a physician? Yes / No

Physician _____ Phone # _____

Are you under the care of other health practitioners (counselor / acupuncturist / physical therapist / etc.)

Name _____ Phone _____ Specialty _____

Name _____ Phone _____ Specialty _____

Medications / Herbal Supplements: _____

I understand yoga and bodywork are not substitutes for seeking medical attention. I will keep my therapist informed of any changes in my health so that my therapist may modify practices as needed to provide for my safety and comfort.

Client's name (please print) _____

Signature _____ Date _____