Health Assessment Questionnaire

Student: ____________________ Date: ____________________

Address: ____________________ Phone: ____________________

____________________ Email: ____________________

Emergency Contact Name and Phone: ____________________

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Diagnosis Date: ____________________

Symptoms:	Now	In the Past	When	Duration
Balance				
Bladder				
Bowel				
Cognitive				
Depression				
Fatigue				
Mobility, Gait and Muscle Weakness				
Pain				
Pregnancy / Post-partum				
Pseudo-exacerbations				
Sexual				
Spasticity				
Vision				
Other symptoms				

Describe in detail symptoms and concerns including side of the body if applicable: __________

____

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Other Health Factors:	Now	In the Past	When	Duration
Cancer				
Diabetes				
Heart Disease				
Menopause				
Nutrition				
Osteoporosis				
Scoliosis				
Sleep Disorders				
Smoking				
Stress				
Other				

Describe in detail other health factors and concerns including side of the body if applicable: __

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Name: ______________________ **Date:** ____________________

Medications:	**Frequency:**	**Side Effects:**

Mobility Aids	**Now**	**In the Past**	**When**	**Duration**
Cane				
2 Canes				
Walker				
Leg braces				
Wheelchair				
Scooter				
Other				

Fitness Activities:	**Now**	**In the Past**	**When**	**Duration**

Physical / Psychological including injuries and surgeries:	**Now**	**In the Past**	**When**	**Duration**

Primary Care Provider: ______________________

Other Health Care Providers:

- Acupuncture ______________________
- Chiropractor ______________________
- Massage Therapy ______________________
- Physical Therapy ______________________
- Psychotherapy ______________________
- Other ______________________

Reason for taking this yoga class: ______________________

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Reminder to the student: Although this form will be kept on file, please be sure to update this information should the condition of your health change. Also, remember that it is always recommended that you talk to your health care provider before beginning any sort of exercise program.

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Student: ____________________ Date: ____________________
Address: ____________________ Phone: ____________________
____________________ Email: ____________________

Desired Outcomes:	**Date:**	**Outcome:**	**Date:**
Better posture			
Better balance			
Improved bladder control			
Less constipation			
Improved memory			
More energy			
Sleep better			
Sexual intimacy			
Reduce stress			
Less spasticity			
Better mobility			
Less pain			
Breathe better			
Other			

Yoga Strategies:

Asana ____________________

Chakra Balancing ____________________

Chanting ____________________

Dosha Balancing ____________________

Guided Imagery ____________________

Kosha Focus ____________________

Mantra ____________________

Meditation ____________________

Pranayama ____________________

Restoratives ____________________

Yamas and Niyamas ____________________

Yoga Nidra ____________________

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