# Yoga Therapy Intake Forms

DISCOVER
Yoga & Physical Therapy

**Today's Date:_____**

Name _____
Age _____
DOB _____

_____ _____ _____
Phone (s) Email

_____ _____
In case of emergency contact Phone

_____ _____
Physician Phone

**Reason for visit/onset of disease or problem:**

**Previous significant medical history:**

What are your top 5 goals for therapy:
1._____
2. _____
3. _____
4. _____
5. _____

What hobbies or activities do you enjoy?
_____
_____
_____

What hobbies or activities do you dislike?
_____
_____
_____

List some of your staple foods in your diet. In other words, what do you typically eat everyday?
_____
_____
_____

Location of your pain today:
_____
_____
_____

Pain on scale of 0 – 10 (0 being no pain and 10 being emergency room type excruciating pain)
Currently ____ Pain at its best ____ When? _____
Yesterday ____ Pain at is worst ____ When? _____

**Are you on, have you had, or do you use:**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Surgery | ___ | ___ | Scars | ___ | ___ |
| If so, list:_____ | | | If so, list location: _____ | | |
| _____ | | | Blood transfusion | ___ | ___ |
| _____ | | | Alcohol | ___ | ___ |
| Medications | ___ | ___ | If so, list frequency:_____/week | | |
| If so, list:_____ | | | Glaucoma | ___ | ___ |
| _____ | | | Cigarettes | ___ | ___ |
| _____ | | | If so, list packs/day:_____ | | |
| Kidney problems | ___ | ___ | Anxiety | ___ | ___ |
| Diabetes | ___ | ___ | Panic attacks | ___ | ___ |
| Osteoporosis | ___ | ___ | Asthma | ___ | ___ |
| Osteopenia | ___ | ___ | COPD | ___ | ___ |
| Detached retina | ___ | ___ | Congestion | ___ | ___ |
| Heart disease | ___ | ___ | Insomnia | ___ | ___ |
| Hypertension | ___ | ___ | Urinary tract infections | ___ | ___ |
| High cholesterol | ___ | ___ | Sensitive to light | ___ | ___ |
| Hearing problems | ___ | ___ | Sensitive to heat | ___ | ___ |
| Depression | ___ | ___ | Sensitive to cold | ___ | ___ |
| Stroke | ___ | ___ When?_____ | Sensitive to sound | ___ | ___ |
| Heart attack | ___ | ___ When?_____ | Sensitive smell | ___ | ___ |
| Nausea | ___ | ___ | | | |

Headaches ___ ___ If so, please describe:_____
Dental problems ___ ___If so, please describe:_____
Jaw pain ___ ___
Cancer ___ ___ When and what type?_____
Food Allergies ___ ___
If so, list:_____
Drug Allergies ___ ___
If so, list:_____

**Metabolic condition:**

How is your appetite?_____
How is your digestion?_____
How is your general circulation?_____
Do you consider yourself to have good dietary habits?_____
Please list any other problem or issue that has not been addressed:_____
_____
_____
_____

_____ _____
Patient Signature Date