Yoga Therapy Health Assessment Questionnaire

Name _____ Date _____

Symptoms	Now	Past
Balance		
Brain Function		
Depression		
Fatigue		
Mobility		
Muscle Weakness		
Pain		
Vision		
Other		

Discuss any additional details regarding symptoms or concerns _____
_____
_____

Health Factors	Now	Past	Duration
Cancer			
Diabetes			
Hearth Disease			
Menopause			
Nutrition			
Osteoporosis			
Scoliosis			
Sleep Disorders			
Stress			
Other			

Describe any details regarding your other health factors _____
_____
_____

Injuries/Surgeries	When?	Outcome?

Discuss any details regarding injuries/surgeries _____
_____
_____

Fitness Activities	When?	Outcome?
	Now Past	
	Now Past	
	Now Past	

Goals	Now	Later	Results
Better Posture			
Better Balance			
More Energy			
Better Sleep			
Reduce Stress			
Better Mobility			
Better Flexibility			
Less Pain			
Better Breathing			
Other			

Talk to your doctor before beginning any exercise program. Please update this form as needed. Thank you.