



PERSONALIZED SELF-CARE PROGRAM FOR  
CHRONIC LOW BACK PAIN  
PERSONAL HEALTH HISTORY

*This questionnaire is an important tool for helping your instructor insure your safety and the appropriateness of your yoga experience. This information is only for your instructor's use and will be held in the strictest confidence. Thank you for taking the time to complete this form.*

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Emergency Notification Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Your Age \_\_\_\_\_

*Please answer in detail if questions apply and enter N/A for not applicable.*

Do you have any experience with stress management, yoga or meditation? Please explain.

How would you describe your overall health?

Are you satisfied with your posture? If no, what would you like to address?

What kind of work do you do?

Are you comfortable at work?

What do you do for exercise?

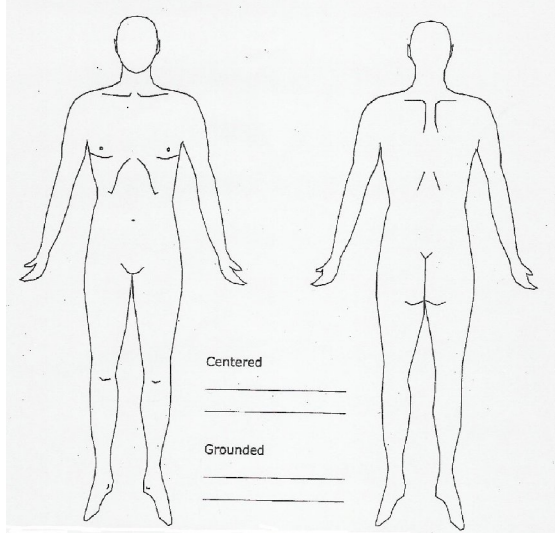
What do you do for relaxation and stress reduction?

Current health challenges:

Are you seeing a health care provider, and if so, what for?

Are you taking any prescription / non-prescription drugs, and if so, what for?

Are you in pain currently, and if so, what is the location of the pain? (mark on body below)



Rate your pain level on a scale of 1–10 (**10** need to go the emergency room, **1** hardly feel the pain)

1      2      3      4      5      6      7      8      9      10

Do you have or have you had: (Check all that apply.)

- |   |  |
|---|--|
| <input type="checkbox"/> High blood pressure            | <input type="checkbox"/> Low blood pressure                  |
| <input type="checkbox"/> Glaucoma                       | <input type="checkbox"/> Osteoporosis                        |
| <input type="checkbox"/> Seizures                       | <input type="checkbox"/> Diabetes                            |
| <input type="checkbox"/> Rheumatoid arthritis           | <input type="checkbox"/> Anemia                              |
| <input type="checkbox"/> Heart Problems                 | <input type="checkbox"/> Asthma                              |
| <input type="checkbox"/> Other breathing problems       | <input type="checkbox"/> Dizziness, vertigo, loss of balance |
| <input type="checkbox"/> Unexplained falls or fractures | <input type="checkbox"/> Hearing difficulty                  |
| <input type="checkbox"/> Hernia / rupture               | <input type="checkbox"/> Unstable – “trick” joint(s)         |
| <input type="checkbox"/> Joint dislocation              | <input type="checkbox"/> Metal implants/artificial joints    |
| <input type="checkbox"/> Bladder problems               | <input type="checkbox"/> Bowel problems                      |
| <input type="checkbox"/> Pinched nerves                 | <input type="checkbox"/> Disc problems                       |
| <input type="checkbox"/> Cancer                         | <input type="checkbox"/> Broken bones                        |
| <input type="checkbox"/> Allergies                      | <input type="checkbox"/> Neurological diseases               |
| <input type="checkbox"/> Headaches                      | <input type="checkbox"/> Vision difficulties                 |
| <input type="checkbox"/> Chest pain                     | <input type="checkbox"/> Shortness of breath                 |
| <input type="checkbox"/> Night sweats                   | <input type="checkbox"/> Joint swelling                      |
| <input type="checkbox"/> Traumatic auto accident        | <input type="checkbox"/> Trouble with balance                |
| <input type="checkbox"/> Addiction to drugs/alcohol     | <input type="checkbox"/> Gastritis/ulcer                     |
| <input type="checkbox"/> Anxiety                        | <input type="checkbox"/> Aids/HIV                            |
| <input type="checkbox"/> Depression                     | <input type="checkbox"/> Hernia                              |
| <input type="checkbox"/> Tuberculosis                   | <input type="checkbox"/> Digestive problems                  |
| <input type="checkbox"/> Hypertension                   | <input type="checkbox"/> Eating disorder                     |
| <input type="checkbox"/> Epilepsy                       | <input type="checkbox"/> Hypoglycemia                        |
| <input type="checkbox"/> Emphysema                      | <input type="checkbox"/> Orthopedic problems                 |
| <input type="checkbox"/> Chronic Back pain              | <input type="checkbox"/> Acute Back Pain                     |
| <input type="checkbox"/> Unexplained Back pain          | <input type="checkbox"/> Sleep disorders                     |
| <input type="checkbox"/> Candida                        | <input type="checkbox"/> Suicidal tendencies                 |
| <input type="checkbox"/> Chronic fatigue syndrome       | <input type="checkbox"/> Thyroid / endocrine problem         |
| <input type="checkbox"/> Major surgeries If yes:        |  |

Type of Procedure(s) and Date(s) \_\_\_\_\_

Outcome: \_\_\_\_\_

\_\_\_\_\_

Women Only:

\_\_\_\_\_ Hysterectomy  
\_\_\_\_\_ Caesarian delivery  
\_\_\_\_\_ Are you pregnant?

\_\_\_\_\_ Menopausal challenges  
\_\_\_\_\_ Early termination of menses  
\_\_\_\_\_ Any condition not described? Please explain

**What would you like most to gain from this program of yoga? (Check all that apply.)**

\_\_\_\_\_ Muscle strengthening  
\_\_\_\_\_ Muscle Stretching and Flexibility  
\_\_\_\_\_ Diet  
\_\_\_\_\_ Lifestyle  
\_\_\_\_\_ Improved Body Awareness  
\_\_\_\_\_ Improved breathing  
\_\_\_\_\_ Improved sleep  
\_\_\_\_\_ Ability to identify stressors  
\_\_\_\_\_ Greater peace of mind

\_\_\_\_\_ Overall posture improvement  
\_\_\_\_\_ Stabilization of joints  
\_\_\_\_\_ Digestion and elimination  
\_\_\_\_\_ Pain reduction  
\_\_\_\_\_ Specific postures or practices  
\_\_\_\_\_ Improved energy level  
\_\_\_\_\_ Breath awareness  
\_\_\_\_\_ Overall stress reduction  
\_\_\_\_\_ Other goals – Please list

***General Health Questions:***

Do you: smoke \_\_\_\_\_ frequency? \_\_\_\_\_ drink alcohol \_\_\_\_\_ frequency \_\_\_\_\_

Does your regular schedule change from day to day?

Any difficulties noticed with breathing? Please describe.

Do you notice changes in your breathing when you become upset or agitated? Please describe.

Describe your overall energy level / stable or variable / high or lethargic, etc.

Do you get to sleep easily and rest well through the night?

Do you wake up feeling refreshed to start your day?

If there are energy fluctuations, when do you feel them?

What is your stress level? Low                      Moderate                      High                      Off the chart

What tends to bring on or trigger effects of stress in your life?

Anything else you want to share that might be relative to this therapeutic program?

***Again, thank you for taking your time with this information as it will assist us in keeping you safe and developing your personal health exercise program.***

***Office Use: Private Session time***