Confidential Client Information

Name: ______________________________ **Date:** _________________________

Mailing Address: ____

Cell phone: _____________________ **Home telephone:** ____________________

Email: ____

Date of Birth: ___________________ **Occupation:** _______________________

Referred by: ____

Are you doing any other types of body work? (physical therapy, chiropractic, osteopathic, energy work?) If so, when was your last treatment?

Describe any regular physical activities (including work-related, recreational, or sports):

Do you do aerobic activity?

How many hours do you spend sitting each day?

Please describe any experience that you have with relaxation and/or meditation.

How is your sleep?

Please indicate your consumption levels

	None	Light	Moderate	Heavy	*Please leave blank*
Salt					
Sugar					
Caffeine					
Tabacco					
Alcohol					
Water					
Processed Carbs					
Protien					
Fat					
Fruit					
Vegetables					

List/describe *(Please use the back of sheet if necessary)*
Current medical issues:

Medications and conditions:

Allergies/allergic reactions:

History of serious illnesses, surgeries, and/or injuries:

Women only: Could you be pregnant at this time?

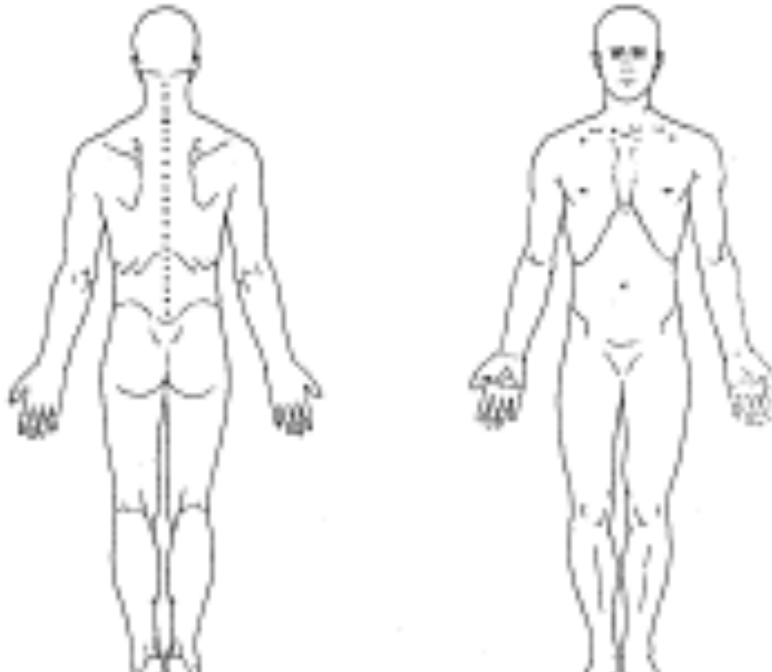
Please mark "C" for currently experiencing and "P" for previously experienced:

__ High blood pressure
__ Stroke
__ Heart condition
__Diabetes
_ Surgery
__ Dental Surgery
__ Tumors
__ Cancer
__ Fibromyalgia
__ Lupus

__ Recurrent Headaches
__ Digestive issues
__ Shingles/Herpes Zoster
__ Serious Cuts/Burns/ Bruises
__ Inflammation
__ Skin conditions
__ Skin infections
__ Varicosities
__ OTHER (describe)

___ Arthritis
__ Joint pain
__ Osteoporosis
__ Bursitis
__ Sciatica
__Broken Bones
__ Fractures
__ Sprains/Strains
__ Numbness/Tingling
__ Automotive Accidents
__Scoliosis
__Disc issues
__Other back issues

Please mark any areas that are experiencing discomfort (and let me know if there are any areas that should be avoided



WHAT ARE YOUR HEALTH GOALS?

Exercise/ Yoga asana -

Nutrition -

Relaxation/Breath work/ Meditation -

The information that you provide is important in helping me to devise an appropriate treatment plan. Yoga Therapy represents a therapeutic treatment modality that can be beneficial for a variety of conditions, but it cannot be used to diagnose medical conditions. Yoga Therapy is not a replacement for medical care.
This information is CONFIDENTIAL and will not be discussed with anyone else.

I affirm that I have stated all my known medical conditions and answered all questions honestly.
I understand that Yoga therapy sessions with Nancy Candea are not a replacement for medical care.
I will keep Nancy up to date on any health changes that I am experiencing
I will let Nancy know if I experience any pain or discomfort in the session during adjustments, exercise or because of any other reason.
I am responsible for paying for any appointment cancellations of less than 24 hours.

Signature **Date**

Please contact me if you have any questions regarding filling out this form
nancycandea9@gmail.com