

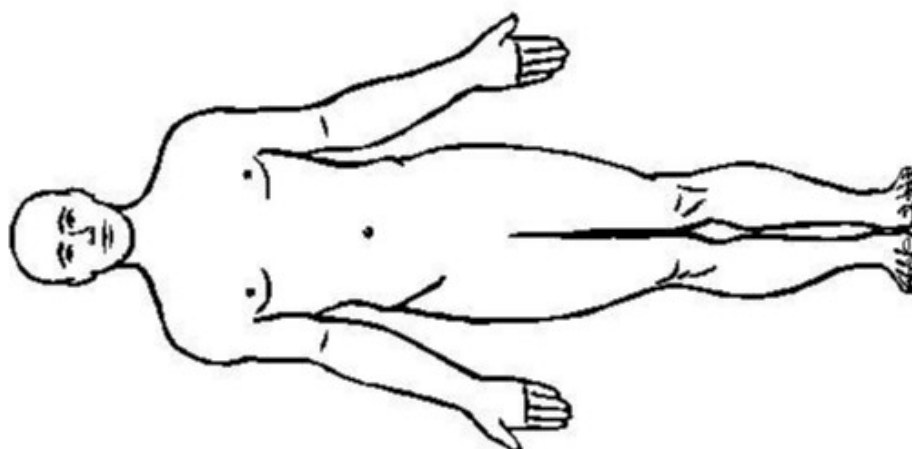
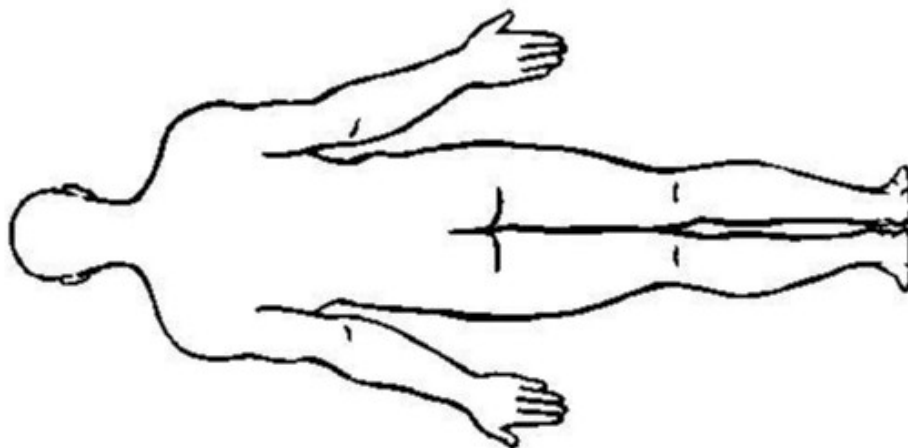


Return to Balance Yoga & Movement Therapy

Self assessment # 1

Date: _____

Make notes of your areas of tension, tightness or pain. Feel free to use the extra space to write your comments.





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What is the main reason you are reaching out for help? _____

Primary Concern: _____

History of Primary Concern:

When did it start? _____

Is it constant? Intermittent? How frequent? _____

Describe the quality (what does it feel like?) _____

Where do you feel it? _____

Intensity of pain (0-10) _____

When does it hurt most? _____

What makes it worse? _____

What makes it better? _____

How does it affect your daily life? _____

What do you think the cause is? (or what have you been told?) _____

What have you tried previously? _____

How has it worked for you? _____

What are your goals? What do you want to achieve? _____

Why is that important to you? _____



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Is anything else bothering you?

Secondary Concern: (if applicable) *Use the same criteria as above to evaluate _____

Overall assessment of Physical / Emotional state: (include anything you feel is relevant)

Aches / Pains (not mentioned above) _____

Energy level _____

Stress level _____

Body awareness _____

Physical activity (past, current) _____

Social activity _____

Home life / environment _____

Job demands / environment _____

Sleep _____

Diet _____

Self care practices & regularity _____

Anything else you would like to add? _____
