RETURN TO BALANCE
YOGA & MOVEMENT THERAPY

RETURN TO BALANCE
PRIVATE SESSION HISTORY FORM

All information received on this form will be treated as strictly confidential.
Please fill out the form as accurately as possible. This information is essential in helping to develop a training program that addresses your needs, goals & interests, and is safe and effective for you.

NAME: _____ DATE: _____

ADDRESS: _____

PHONE: _____ EMAIL: _____

BIRTH DATE: _____

OCCUPATION: _____ HRS WORKED PER WEEK: _____

EMERGENCY CONTACT: _____ PHONE: _____

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1. What are your primary concerns at this time:

2. How does it affect your daily life?

3. What is your ultimate goal or major health goals, from a big-picture perspective:

4. What has worked before to help you move closer toward your goals?

5. What has not worked before?

6. What would success look like to you, if we were to work together?

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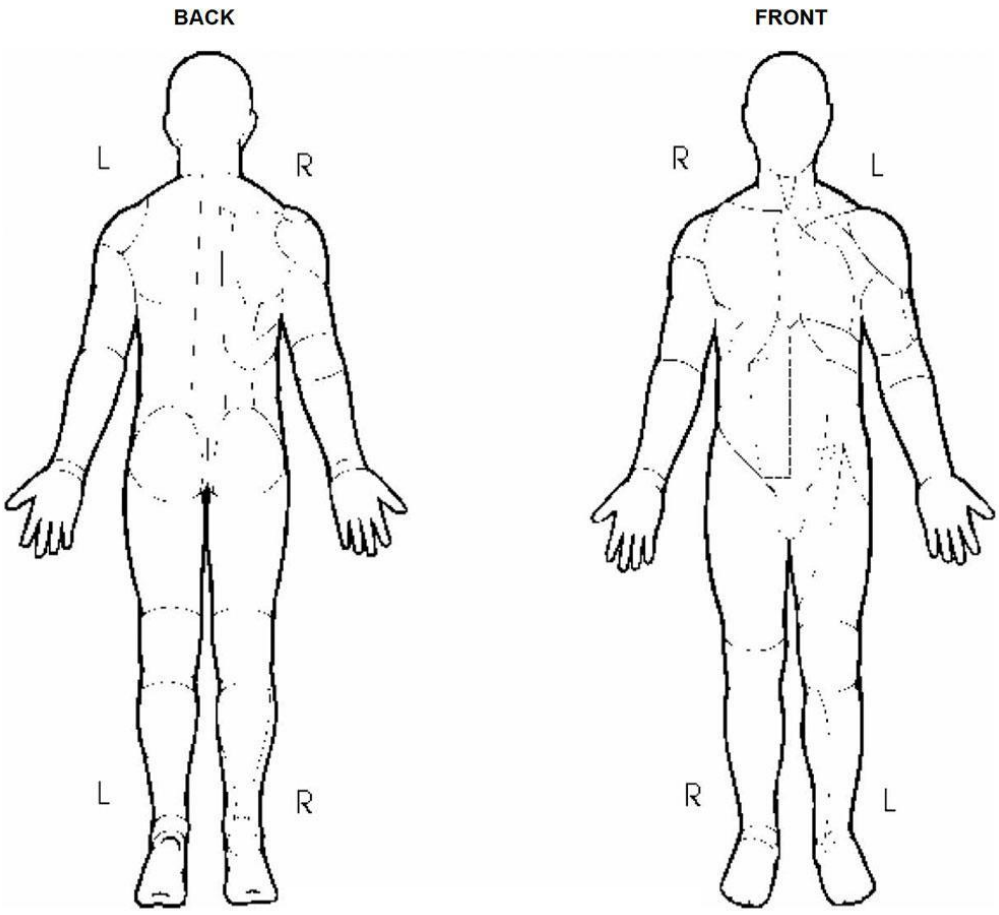
NAME: _____ DATE: _____

Please Mark on the Diagram & Describe Any Areas of Pain/Tension/Discomfort:

(Use a separate sheet if necessary)



Onset: How did it start? (Sudden Trauma, Gradual, etc.)

Duration: How long have you had the issue?

Frequency: How often does it bother you? (Rarely, Always, etc.)

Type/Quality: What does it feel like? (Sharp, Dull, Broad, Tingling, Radiating, etc.)

Severity/Intensity: How bad is the pain? (1-10 Scale, or Mild/Moderate/Severe)

Aggravation/Improvement: What makes it better? What makes it worse?

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Health & Injury History:

In this section, please list ALL major injuries, surgeries, hospitalizations, and major illnesses from childhood until now that you can remember. If needed, please attach additional documents.

Be sure to include information on these areas as they are important to our neurological systems:

- **Head Injuries, Concussions, Whiplash? When?**

- **Broken bones, fractures, major sprains? When?**

- **Dental Surgeries & Dental Work? When? Any side-effects?**

- **Dizziness, Vertigo, Motion Sickness? When? What triggers it?**

- **Do you wear glasses or contacts? Have you had vision surgery? When?**

- **Do you have tattoos or other scars not listed above? How many? When? Body Location?**

- **Eyes / Ears / Nose / Mouth / Throat? GI system function?**

- **Numbness &/or Tingling?**

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Lifestyle Information:

Do you engage in physical activity on a regular basis?

What sports & activities did you enjoy or play in your life?

What sports & activities do you like to participate in now?

What would you like to be able to do?

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

Energy level _____

Stress level _____

Social activity _____

Home life / environment _____

Job demands / environment _____

Sleep _____

Diet _____

Self care practices & regularity_____

Anything else you would like to add/share before we begin?