

EAST WEST yoga

- MEDICAL INFORMATION & CONSENT -

Date (MM/DD/YYYY): _____

Client Name: _____

Date Of Birth (MM/DD/YYYY): _____

Email: _____

Phone Number(s) Home: _____

Cell: _____

Work: _____

Address Street: _____

City: _____

Postal Code: _____



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OF MEDICINE & SPIRITUALITY

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Medical Doctor Name: _____

Phone Number: _____

Emergency Contact: Name: _____

Relevant Phone Number(s): _____

Email: _____

Reason For Seeking Healing Services?

How Did You Hear About The Centre?

Relevant Past Medical History:
(please outline past medical conditions & surgeries of relevance)



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Medications (please list, including herbal supplements, vitamins etc):

Allergies / Sensitivities: (please list relevant concerns)

Occupation:

Lesiure Activites:

Are you receiving concurrent therapies / treatment ?
(ie. physiotherapy/massage/ chiropractics or energy healing?)

Are you pregnant? If so what trimester?

Do you bruise easily?

Have you had acupuncture before?



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Do you have a fear of needles?

Describe your diet & eating patterns?

How much water do you drink per day?

Describe your exercise / activity patterns?

Describe your sleeping patterns?

- number of hours / night ?
- do you fall asleep easily?
- do you wake up in the night?
- average wake up time?
- average go-to-bed time?

Please outline your goals for healing session today:



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Location of Pain:

Nature of Pain: (ie. sharp or dull ache)

Intensity Of Pain:

(Please circle your present pain on the visual analog scale below.

Pain Scale: 0 = no pain & 10 = the worst pain imaginable for you

0 1 2 3 4 5 6 7 8 9 10

What makes the condition / pain worse?

(ie. movement, sitting, lying down?)

What time of day are the symptoms worse?

(ie. first thing when you wake up, night-time, or the end of the day?)

What improves the condition / pain?

(ie. ice , heat, massage, medications etc)



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Do you have any of the following?

Please write 'yes' beside each condition that is applicable. If applicable, please describe in detail in the space provided beside each pertinent condition(s):

Severe Headaches / Migraines

History of TIA's

Seizures

Dizziness

Fainting

Nausea

Numbness / Tingling

Visual Blurring or Disturbances

Balance Issues

Recent Weight Loss (>10 lbs)

Night Pain

Hepatitis or HIV

Diabetes

Heart Disease

Cancer



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- Consent and Disclaimer For Healing Services -

The affixing of my name and initial below hereby acknowledges my consent to healing service and disclosure of medical information. I consent that the information above is correct and complete with no omission regarding health or injury or any other relevant medical information to the best of my knowledge.

Full Name

Initial

Date



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