

Living Room Yoga Wellness Questionnaire

1. Name: _____

2. Address: _____

3. Phone: _____

4, Alternative Phone: _____

5. Email: _____

6. Do you receive our E-Newsletter? _____

7. Birth Date: _____

8. Name and phone number of healthcare provider: _____

9. Medications you are on and what they are for:

10. What modality are you coming in for? Yoga therapy, cranial sacral therapy, hypnosis, or hypnotherapy? _____

11. What is your experience with the modality your are coming in for?

12. What would you like the outcome of your private appointment to be?

13. If your body could talk what would it say about its state of being?

14. How is your diet and digestion? _____

15. Where do you have muscle pain or tension? _____

16. How would you describe your posture? _____

17. What kind of work do you do? _____

18. Is your body comfortable at work? _____

19. What kind of exercise do you do and how often? _____

20. What do you do for stress reduction and relaxation (feel free to share any unhealthy habits as well as healthy ones): _____

21. What major surgeries have you had? _____

22. What chronic conditions do you have? _____

23. List any accidents or injuries with approximate dates: _____

24. What are your main health challenges right now?

25. To what extent do these challenges restrict your daily life?

26. Is your schedule regular or irregular? _____

27: Do you have any problems with breathing? _____

28. Do you notice changes in your breath when you become upset or agitated?

What happens? _____

29. Were you ever a smoker? _____

30. If you are still a smoker, do you want to quit? _____

31. Is your energy level low, medium, or high? _____

32. Does your energy level fluctuate? When do you have dips?

33. What are your sleep patterns like? _____

34. Do you wake up refreshed? _____

35. Is your stress level low, medium, or high? _____

36. What triggers your experience of stress? _____

37. What do you find most effective for releasing stress? _____

38. Do you find yourself getting upset or irritated often? _____

39. Do you experience anxiety? _____

40. Do you experience depression? _____

41. What emotions do you have difficulty experiencing or expressing?

42. Are personal relationships nurturing and supportive? _____

43. Is your career fulfilling? _____

44. What are your main life challenges at present? _____

45. What have been your most significant losses? _____

46. Do you have friends you can confide in? _____

47. Do you notice that you keep bumping up against the same problems or situations in life? What are they? _____

48. What habits would you like to change? _____

49. Do you have the big picture of your life or do you feel stuck in the forest just looking at the trees? _____

50. How would you describe the spiritual dimension of your life?

51. What are the most important things in life? _____

52. Do you feel like you have a particular mission in this life?

53. If so, are you fulfilling it? _____

Personal Goals

Please check the goals below that are most important to you

Muscle Strengthening (Which?) _____

Flexibility (Where?) _____

Joint Stability (Which?) _____

Improve digestion and elimination

Improve posture

Improve overall health

Improve diet and develop healthier lifestyle

Reduce pain (Where?) _____

Increase body awareness

Learn specific postures or aspects of yoga _____

Improve breathing

Increase energy

Stabilize energy

Improve sleep

Reduce experience of stress/attain greater peace of mind

Handle emotions better

Be able to feel emotions in the body

Get less upset and irritated

Feel less anxious

Feel less depressed

Have more satisfying personal relationships

Find greater fulfillment in my work life

Improve self-esteem

Gain a wider vision of life

Grow spiritually

Change habits (Which?) _____

See and change dysfunctional behavior patterns

Have more control over the direction of my life

Have a sense of living life fully

Have a lived experience of the meaning of life