**YOU MATTER HEALTH INVENTORY**

Name _____ DOB _____ Todays Date: _____

Phone _____ Email _____

Address: _____

City: _____ State/zip: _____ County: _____

Emergency contact/relationship/phone_____

Gender Identification: _____ Profession: _____

What brings you here today?

_____

_____

Please describe any current physical issues (in addition to any listed above) that you are dealing with today. Include what and how long and if you are being treated by a healthcare practitioner for that issue.

_____

_____

_____

_____

Please list current medical team (ie primary care physician, medical specialists, rehabilitation professionals, behavioral health specialists, dieticians/nutritionists, etc) and contact information.

_____

_____

_____

_____

_____

Please list surgical history and dates.

_____

Please list medications (Rx/OTC) Include name, purpose and how long you have taken them:

_____

_____

_____

Supplements / Herbs:

_____

_____

Do you have any allergies? (food allergies, medication allergies, seasonal, scent related, etc) Please list below.

_____

_____

_____

How would you describe your activity level daily: Sedentary Moderately active Very Active

Are you satisfied with your current level of activity? _____

How many hours a day do you sit? Weekday: _____ Weekend: _____

What activities do you enjoy doing in your leisure time? List approximately how many days a week you participate in these and for how long? _____

_____

_____

_____

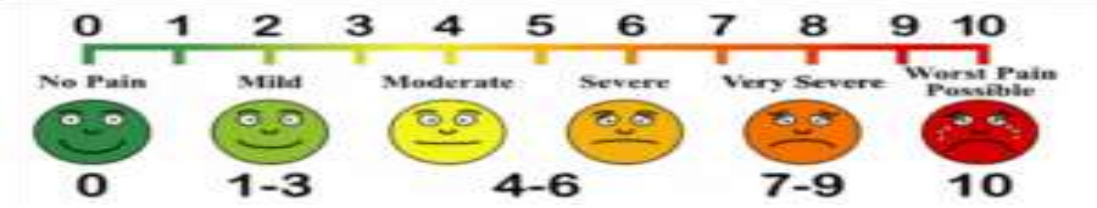
_____

_____

_____

**Current pain or discomfort**

Are you currently working through body discomfort? If so, please list the areas of discomfort along with an average discomfort rating. Please use the following guideline in rating your discomfort level and feel free to add any additional information you want to share.




Area of discomfort Average discomfort rating Rating at worst Rating at best

_____

_____

_____

_____

How have the above concerns limited activities of daily living or any activities you enjoy?

_____

_____

_____

Of the areas listed above, which is your greatest concern at this time? Why are you most concerned about this area?

_____

_____

_____

Are there any activities/strategies that help decrease discomfort in any of the areas listed? Please describe the strategies utilized to help manage discomfort levels.

_____

_____

_____

Have you been treated for any of the areas listed in the previous section by a rehabilitation professional (ie acupuncturist, chiropractor, massage therapist, physical therapist, etc)? If so, please describe your experience with the intervention(s) (ie treatments utilized, effectiveness of treatment with discomfort level, functional changes, etc).

_____

_____

_____

_____

_____

**Dietary Information**

Do you feel you are eating a healthy nutritious diet currently? _____

_____

How would you describe your typical daily food intake/nutritional status?

_____

_____

_____

_____

_____

_____

Current daily fluid intake

Please estimate how many ounces of water you drink daily: _____

Caffeinated beverages: _____ Type: _____

Energy drinks/soda: _____ Other:_____

Please describe your current sleep status. (ie hours/night, sleep quality, sleep issues, etc)

_____

_____

_____

Please mention any significant feelings, emotions, stresses, issues or relationships in your life that you are struggling with:

_____

_____

_____

_____

_____

During the past month have you often been bothered by feeling down, depressed, or hopeless?*

_____

During the last month have you often been bothered by little interest or pleasure in doing things?*

_____

Would you like help with regard to your responses to the previous two questions?*

_____

Are you currently involved in any support groups, spiritual groups, or other social outlets they you feel are crucial to your well- being? Please feel free to share specifics regarding your current social outlets.

_____

_____

_____

_____

Please write three things you are grateful for today:

1. _____
2. _____
3. _____

What are your goals for the therapeutic yoga process?

_____

_____

_____

In the course of a typical week, how much time are you able to commit to the process of achieving these goals? Do you perceive any barriers in committing this time?

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_____

_____

Please share anything else you would like your yoga therapist to know.

_____

_____

_____

_____

_____

Signature: _____ Date signed: _____

*Corresponds to Arroll et al Depression screening intake.