



Balance & Bliss™, Inc.

Yoga and Ayurveda

Client Personal History

Name _____ Date _____

Have you consistently experienced any of the following? Are you currently?

	When?	Current?		When?	Current?
Abdominal Pain			Headaches		
Addiction Problems			Heart Problems		
Allergies			High Blood Pressure		
Arthritis			Low Blood Pressure		
Asthma			Menstrual Irregularity		
Bladder/Kidney Problems			Miscarriage		
Blurred/Double Vision			Menopausal Symptoms		
Circulatory Problems			Pre Menstrual Symptoms		
Constipation			Respiratory Problems		
Diabetes			Sinus Infections		
Diarrhea			Skin Problems		
Digestive Problems			Sleeping Problems		
Dizziness			Stomach Ulcers		
Exhaustion/Fatigue			Thyroid Imbalance		
Fainting			Varicose Veins		

Have you had any major injuries, emotional/mental stresses, diseases, illnesses or surgeries? Please list, including time frame and any current effects

Illnesses on your father's side of the family _____

Illnesses on your mother's side of the family _____

Are you currently under a physician's care? _____ Please explain _____

Date of last physical exam? _____ Results? _____

Please list any of the following that you are currently taking or consuming:

Prescription drugs _____

Non-prescription drugs _____

Vitamins or Nutritional Supplements _____

Herbal Teas or Capsules _____

Alcoholic Beverages _____

Tobacco Products _____

Do you have a healthy diet?

Always _____ Most of the time _____ Sometimes _____ Rarely _____ Not at All _____

Do you currently engage in an exercise routine or physical activity?

1 x per day _____ More than 1 x per week _____ 1 x per week _____ Seldom _____ Not at All _____

What type of exercise or activity? _____

How many children live at home with you? _____

Do you enjoy your work? _____

What is your level of happiness in your major relationships? _____

What do you consider to be your major life stressors? _____

Female Clients

Date of last menstrual period _____ Are you currently pregnant? _____ If yes, how many months

_____ Are you breastfeeding? _____ If yes, how long _____ How many pregnancies have you

had? _____ How many children do you have, please list gender and ages _____

Other Comments _____

DENISE O'DUNN, RYT500

Certified Ayurvedic Practitioner and Yoga Instructor

PHONE: 727.823.8743 FAX: 727.820.0486

EMAIL: enjoyoga.om@gte.net WEB: balanceandbliss.com