Balance & Bliss™ Inc.

Ayurveda • Yoga • Massage

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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

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

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Are you currently pregnant? __________ If yes, how far along _______________________________

Please list any medications that you are currently taking:

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