Arizona Medical Yoga Professionals
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WELLNESS SCREEN

Patient Name:_______________________________________ Today's Date:______/______/______
Date of Birth:______/_______/______ Age:_________ Gender: Male/Female
Address:_________________________________City:_________________State:_____Zip:_______
Cell Phone:_______________________________ Email :____________________________
Emergency Contact Name:______________________________Phone:_________________________
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Do you have a fever, recent illness, loss of taste/smell, been exposed to/diagnosed with COVID-19, or traveled in the past 2 weeks? circle one **YES (details?** ______________________ **NO**

Do you have any specific goals in Yoga?

____
____

Do you have any current complaints/concerns regarding pain or limits of functional mobility?

____
____

If above answer is YES, have you had any medical treatment for this concern/complaint:

____
____

Diagnostic Tests and results:

____
____

Current aggravating factors & effect:

____
____

Current easing factors & effect:

____
____

Informed Consent & Liability Release: I (or on behalf of the patient/client), consent for Raquel Lines, PT, PYT-C to guide me in a medical therapeutic yoga class and give recommendations for a home practice. I have been informed and acknowledge that in using the facility, equipment, and services of AZ Medical Yoga Professionals, I do so at my own risk. I understand and I am aware that strength, flexibility, and cardiovascular exercise including the use of equipment, is a potentially hazardous activity and that I am voluntarily participating in these activities. I do hereby declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would limit my participation. I acknowledge that I have either had a physical examination and have been given my physician's approval to participate in exercise, or that I have decided participate in exercise without the approval of my physician. I hereby certify that I have read the contents of this Informed Consent and Release of Liability and agree.

Patient/Parent/Client Signature: ____Date______/______/______

MEDICAL SCREENING QUESTIONNAIRE

Please answer the following questions to the best of your knowledge regarding your general heatlh:

Do you have a history of (check all that apply):

____ Lumbar Pain
____ Cervical/Thoracic Pain
____ Headaches/Migraines
____ Numbness/Tingling
____ Pinched Nerve
____ Sciatica
____ Herniated or Bulging Disc
____ Osteoarthritis (DJD)
____ Degenerative Disc Disease
____ Rheumatoid Arthritis (RA)
____ Scoliosis
____ Spondylolisthesis
____ Osteoporosis/ Osteopenia
____ Gout
____ Allergies
____ Ligamentous Laxity or EDS
____ Ankylosing Spondylitis (AS)
____ Diabetes
____ Chest Pain/Angina
____ Shortness of Breath
____ High Blood Pressure
____ COPD
____ Irritable Bowl Syndrome
____ Asthma
____ High Cholesterol
____ Kidney Problems
____ Celiac Disease
____ Hyper/Hypothyroidism
____ Stroke
____ Heart Disease
____ Heart Attack
____ Anemia
____ Hepatitis
____ Nausea/vomiting/vision
____ Wounds/Ulcers
____ Multiple Sclerosis
____ Dementia/Alzheimers
____ Restless Leg Syndrome
____ Lyme Dz/Autoimmune Dz
____ Fibromyalgia/Chronic Fatigue
____ Aids/HIV
____ Dental/Jaw Problems
____ Chron's Disease
____ Personality Disorder
____ Schizophrenia
____ ADD/ADHD
____ Depression
____ Anxiety
____ Bipolar Disorder
____ Autism/Asperger's Disorders
____ Addiction

____ C-Section/Traumatic Births
____ Endometriosis
____ Urinary Tract Infections
____ Hernia (Inguinal/Hiatal/Diastasis/Other)
____ Hormonal Imbalance (PMDD/Menopause)
____ Incontinence (Circle: Bowel/Bladder OR Urge/Stress/Mixed)
____Cancer
____Fracture
____HeadInjuryConcussion
____ Dizziness/Vertigo/Loss of balance/ Falls (How many falls within the last 12 months?_____)
____ MVA:____
____Surgery:____
____Other:____

List all MEDICATIONS, doses, frequency & SUPPLEMENTS you are currently taking (anti-depressants, pain meds, sleep aids, heart or blood pressure meds, cholesterol meds, vitamins, probiotics, etc.):

____________________ ____________________ ____________________
____________________ ____________________ ____________________

List XRAYs, MRIs, CAT, NCV/EMG, BMD & other Diagnostic Tests that have been completed or ordered by your physician:

____________________ ____________________ ____________________
____________________ ____________________ ____________________

Regular Exercise Program &/or current limitations to functional mobility:

____
____

Lifestyle & Habits:

- Overall sleep quality? (circle) Excellent Good Fair Poor
  - How many hours/night? (circle) 0-2 2-4 4-6 6-8 8-10+
  - Sleep position? (circle) back side stomach
  - Difficulty falling asleep or staying asleep? ______________________________
- Typical Workday? (indicate % of each) Standing______ Sitting_______ Walking______ Stairs_______
  How often do you Change your body Position______________________________
- Typical dietary intake: Fruits/vegs________ Protein_________ Carbohydrates_________ Fats_________
  GMO awareness________ organic_________ Food Allergies/sensitivities____________________
  Special diets______________________ Gluten__________ Paleo__________ Vegan_________
- Alcohol Consumption?______ (circle type): Wine Beer Liquor Daily/Weekly/Monthly/sporadic/Never
- Tobacco Use?______ (circle type): Cigarettes Cigars Chew Daily/Weekly/Monthly/sporadic/Never