PRAIRIE YOGA / ALIGN YOUR SELF®

Health History Form

Name: _____ Date of Birth _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Emergency Contact 1: _____ Phone Number: _____

Emergency Contact 2: _____ Phone Number: _____

Are you a Cancer Survivor _____ Caregiver _____ (if Caregiver, please give relationship) _____

Type of Cancer/Location on body _____

Cancer Stage _____ Has there been a recurrence? _____ If yes, when _____

Area(s) on body of recurrence: _____

Surgeries (please list major or recent surgeries first, continue on reverse if needed)	Date

Are you wearing a port or appliance? _____ If yes, please specify where _____

Are you currently receiving chemotherapy? _____ If complete, date ended _____

Are you currently receiving radiation? _____ If complete, date ended _____

Are you currently receiving hormonal or other treatment? _____ If yes, please specify type _____

If complete, date ended _____

Are you experiencing any of the following: High Blood Pressure _____ If yes, is it Controlled or Uncontrolled? _____

Neuropathy _____ If yes, where _____ Osteopenia or Osteoporosis? _____

Lymphedema _____ If yes, where and what are your related limitations? _____

Pain _____ If yes, please describe _____

Depression _____ Anxiety _____ Insomnia _____ Fatigue _____ Low Blood Count __

Do you have any other injuries, symptoms or medical conditions? _____ If yes, please describe: _____

_____

_____

Current medications: _____

Are you aware of any limitations that you have or modifications required for any Wellness class or service? _____

If yes, please describe: _____

_____

Waiver: I am aware of the limitations that I have and I am aware of any modifications that I must make to the wellness activities to make them appropriate for me.

Signature: _____ Date: _____

Print Name: _____