Breathing Space Yoga
& Wellness Services

HOLISTIC HEALTH QUESTIONNAIRE

(Please Print)

Please read each question carefully and check the YES or NO opposite the question as it applies to you. Please answer these questions as accurately as possible in order to assist the Holistic Health Practitioner in providing you with the services that suits your needs as much as possible. If a question is not clear please ask the Practitioner for clarification.

The confidential information on this questionnaire is provided to the Holistic Health Practitioner. By accepting this document, the Practitioner agrees that the information contained herein will not be disclosed to others.

Personal Information

_____ _____
First Name Last Name

Address_____ City_____

Province_____ Postal Code_____ E-mail Address_____

Phone Number (Home)_____ (Bus)_____ (Cell)_____

Date of Birth _____ _____ _____ Age_____ Male ☐ Female ☐
Month Day Year

Do you have children? ☐ Yes ☐ No
Are you employed? ☐ Yes ☐ No
If yes, what type of work do you do?_____

_____

Health History

Is there a history of illness in your family? ☐ Yes ☐ No
If yes, give

details_____

_____

_____

_____

Do you have or have you had any health problems? ☐ Yes ☐ No
If yes, list health problems_____

_____

_____

Have you had injuries? ☐ Yes ☐ No
If yes, give

details_____

_____

Have you been hospitalized? ☐ Yes ☐ No
If yes, give

details_____

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Are you taking medication? ☐ Yes ☐ No
If yes, which ones_____

How is your appetite? ☐ Good ☐ Poor
If poor, give details_____

Do you have any allergies? ☐ Yes ☐ No
If yes, give details_____

How are your bowel movements? ☐ Normal ☐ Irregular
If irregular, give details_____

Are you pregnant? ☐ Yes ☐ No ☐ NA

Lifestyle

Do you smoke? ☐ Yes ☐ No
If yes, for how long?_____ How many cigarettes do you smoke per day?_____

Do you drink? ☐ Yes ☐ No
If yes, how often?_____

Do you eat 3 meals a day or more frequently?_____

Do you snack throughout the day? ☐ Yes ☐ No
If yes, how often?_____

Which of the following food groups do you have per day and how many?
Fruits_____Vegetables_____
Dairy products _____Nuts_____
Grains _____Meats or alternatives_____
Fish _____Fried foods _____
Other_____

How many hours of sleep do you get per day?_____

Do you have difficulty sleeping? ☐ Yes ☐ No ☐ Sometimes

Do you feel rested when you wake up? ☐ Yes ☐ No ☐ Sometimes

How much water do you drink per day?_____

Have you had any major stresses in the past twelve months? ☐ Yes ☐ No
If yes, give details_____

Do you practice any relaxation techniques? ☐ Yes ☐ No
If yes, which ones_____

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What is a typical day like for you?_____

Personality

Does it bother you to be touched? ☐ Yes ☐ No

How do you relieve stress?_____

Do you feel that you are able to cope with stress in your life? ☐ Yes ☐ No

Give examples of your ability or inability to cope with stress_____

Do you have a good support system in your life? ☐ Yes ☐ No

Spiritual/Emotional Health

Do you practice any spiritual techniques such as meditation, church, or other)? ☐ Yes ☐ No
If yes, which ones and how often?_____

Do you usually think positively or negatively? Give details.

How did you find out about this service? Circle all the ones that apply

newspaper / flyer / community newsletter / yellow pages / personal referral

What do you expect from your session today? Please give details.

By signing below, I certify that I have read and answered each question in this questionnaire as accurately as possible.

Client Signature_____Date_____

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