

Please fill out before your first session and email to hello@jessicadateyoga.com

Personal details

Name:	Date:
What name do you prefer us to use/call you by	?
Phone number:	D.o.B:
Address:	Postcode:
Email:	Occupation:
Medicare Number:	
Health care provider and number :	
Do any other family members come here, if so	who are they?
How did you find out about us?	

Jessica Date 406A

Which of these areas are you seeking assistance with?

Spiritual wellbeing

Mental wellbeing

Emotional wellbeing

Physical wellbeing

What are the main reasons you are interested in coming to visit Jess?



Physical Background - Past, Present, Future

Past - Describe any significant history concerning your physical body. Include any accidents, medical intervention, medication, symptoms, toxin or drug exposure. Please include the date:

Have you ever been unconscious? Yes No

Have you served in the military? Yes No

Present - How is your physical body now? Include any health challenges, diagnoses and medication:

Present - What is your typical diet, sleep quality and exercise routine? Please mention any current health practices you are engaged in:

Future - What would your main goal be for your physical body?



Mental/Emotional background - Past, Present, Future

Past - Describe any significant history concerning your mental and emotional life? Please include any major life stresses, traumas or events, as well as any medications or mental and emotional symptoms you may have had:

Present - How is your mental health and emotional life now? Please include any current mental health challenges, diagnoses and medications. Also any current mental/emotional practices you are engaged in:

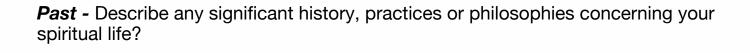
How would you grade your current (recent) levels of stress?

1 2 3 4 5 6 7 8 9 10

Future - What would your main goal be for your mental and emotional life?



Spiritual Life History



Present - How is your spiritual life now?

Future - What would main goal be for your spiritual life?



Additional Information

Sleep			
How old is your mattress?			
How old is your pillow?			
What position do you predominantly slee	p in?		
Toxin Exposure			
Do you consumer any of the following?			
Caffeine/coffee			
Alcohol			
Refined sugars			
Do you take drugs? Yes No	Have you in the past?	Yes	No
Do you use social drugs? Yes No	Have you in the past?	Yes	No
Give a brief description:			