GENESIS TREE OF LIFE
YOGA & WELLNESS CENTER
102-06 METROPOLITAN AVENUE
FOREST HILLS, NY 11375
718-544-5997

Brief Health Information Form

A. Identification
Client's name: _____ Case #: _____ Date: _____

B. History

1. Starting with your childhood and proceeding up to the present, list *all* diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section E.)

Age	Illness/diagnosis	Treatment received	Treated by	Result
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

2. Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. List *all* medications or drugs you take or have taken in the last year—prescribed, over-the-counter, and others.

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(cont.)

4. Have you done any kinds of work where you were exposed to toxic chemicals?

Date	Kinds of chemicals	Kind of work	Effects

C. Medical caregivers

1. Your current family or personal physician or medical agency:

Name	Specialty	Address	Phone #	Date of last visit

2. Other physicians treating you at present or in last 5 years:

Name	Specialty	Address	Phone #	Date of last visit

D. Health habits

1. What kinds of physical exercise do you get? _____
_____
_____

2. How much coffee, cola, tea, or other sources of caffeine do you consume each day? _____
_____
_____

3. Do you try to restrict your eating in any way? How? Why? _____
_____
_____

(cont.)

4. Do you have any problems getting enough sleep? _____
_____
_____

E. For women only

1. At what age did you start to menstruate (get your period):_____

2. Menstrual period experiences:
   a. How regular are they? _____
   b. How long do they last? _____
   c. How much pain do you have? _____
   d. How heavy are your periods? _____
   e. Other experiences during period? _____

3. Please list all of your pregnancies:

		What happened with with pregnancy?			
	Your age	Miscarriage	Abortion	Child born	Problems?
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____

4. Menopause:
   a. If your menopause has started, at what age did it start? _____
   b. What signs or symptoms have you had? _____
   _____

F. Other

Are there any other medical or physical problems you are concerned about? _____
_____
_____
_____
_____

Note: Significant aspects of family medical history should be recorded on "Client Information Form 2."