

# Nirinjan Bikko Yee

PERSONALIZED MOVEMENT TRAINING • THERAPEUTIC BODYWORK

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## INTAKE FORM

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Profession \_\_\_\_\_

What are your goals for personalized movement training and therapeutic bodywork?

## LIFESTYLE

On a scale of 1-5 what is your daily stress level?

On a scale of 1-5 what is your level of physical activity?

What kind of physical activity do you engage in and how often?

What former activities have you performed?

Do you smoke? How much per day?

Do you consume alcohol? How much per day?

**MEDICAL HISTORY**

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

When was your last Physical /Check-up?

Do you have any history of heart disease? (If yes, specify age at time of event or diagnosis)

Do you have any history of breathing or lung problems? (If yes, specify age at time of event or diagnosis)

Do you have any other medical diagnosis?

Do you have any sleeping disorders or trouble sleeping?

Have you had any surgeries or hospitalizations? If yes, please list

Do you have any current or prior injuries? (If yes, specify age at time of event or diagnosis)

Do you have any muscle or joint pain? (If yes, describe the location, side of the body and pain--scale 1-5)

What helps relieve the pain, and what aggravates the pain?

What Supplements, Vitamins, Herbs and Medications do you take at this time?

How often do you feel depressed? frequently \_\_ occasionally \_\_ never \_\_

How often do you feel anxious? frequently \_\_ occasionally \_\_ never \_\_

How often do you feel angry? frequently \_\_ occasionally \_\_ never \_\_

How often do you feel sad? frequently \_\_ occasionally \_\_ never \_\_

How often do you feel happy? frequently \_\_ occasionally \_\_ never \_\_

**Thank you for taking the time to fill out this questionnaire**