

LivingWell Confidential

Mind Body Fitness Health History Form

Name: _____ Date of Birth _____

Address: _____

Town/City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Cancer Survivor _____ Caregiver _____

Type of cancer/location: _____

Has there been a recurrence? _____ If yes, where and when: _____

Surgeries (use reverse if necessary)	Dates

Chemotherapy: Date Ended _____ Continuing _____

Radiation: Date Ended _____ Continuing _____

Hormonal or Pharmaceutical Therapy: Date Ended _____ Continuing _____

Are you wearing a port or appliance of any kind? _____

What medications are you currently taking? _____

Have you experienced any of the following:

High Blood Pressure _____ (if yes, is it _____ Controlled _____ or Uncontrolled)

Neuropathy _____ If yes, where _____

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

Pain _____ If yes, please describe _____

Depression _____ Anxiety _____ Insomnia _____ Fatigue _____

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

Are you aware of any limitations on activity that you have? _____ If yes, please describe:

What type of physical fitness activities are you currently doing?

For yoga students: Have you done yoga before? _____ If yes, where and when:

What do you hope to obtain from the Mind Body Fitness classes?

What currently brings you joy and energy?

Is there anything special that the instructor should know about you?

Waiver: I am aware of the limitations that I have and I am aware of any modifications that I must make to the group activity to make the yoga class appropriate for me.

Signature: _____

Print Name: _____ Date: _____

Release from Doctor:

Received: Yes _____: Date: _____