Y.O.G.A. LLC
Medicinal Herbology Questionnaire

PLEASE PRINT

Date: _____

Name: _____ Date of Birth: _____

Address: _____ Height/Weight: _____

_____ Phone: _____

Occupation: _____

******Two Choices: LEMON or PEPPERMINT (Circle one)******

Personal Area of Interest

- What is the **major area** of health concern for you? (try to narrow it down to three)

- What are the main area(s) you would like to focus on during this Health & Wellness Program?

- What are your desired results?

- How long are you willing or able to follow this program?

Present Health Status

Check each column where symptoms apply. (X) For some experiences;
(XX) For those which occur often; (XXX) For those which are a major concern

Cardiovascular

___ High Blood Pressure
___ Low Blood Pressure
___ Pain in Heart
___Poor Circulation
___Swelling in Ankles/Joints
___Previous Heart Stoke/Murmur

Skin

___Boils
___Bruises
___Dryness
___Itching
___Varicose Veins
___Skin Eruptions

Brandy Manguno brandy@yoga-llc.com (985) 502-7576

PLEASE PRINT

Eyes, Ears, Nose & Throat

___Asthma

___Ear Aches

___Eye Pains, Dry/Wet

___Failing Vison

___Hay Fever

___Sinus Infections

___Sinus Congestion

___Sore Throat

___Tonsils

___Hearing Loss

Urinary /Kidney

____Excessive Urination

___Water Retention

___Burning Urine

___Kidney Stones

___Lower Back Pain

___Dark Circles under your eyes

___Itchy Ears/ Eyes

___Emotional Insecurity

Respiratory

___Chest Pain

___Difficulty breathing

___Cough

___Tuberculosis

___Congestion

Gastro-Intestinal

___Belching

___Colitis

___Constipation

___Abdominal Pain

___Liver Problems

___Gall Stones

___Ulcers

___Indigestion

Muscles/Joints

___Backache/Upper or Lower

___Broken Bones

___Mobility Restrictions

___Arthritis / Bursitis

Brandy Manguno brandy@yoga-llc.com (985) 502-7576

Y.O.G.A. LLC
Medicinal Herbology Questionnaire

PLEASE PRINT

Allergies and Past History

- Do you have allergies? To what?
- Are you allergic to any medicine? Please name them:

  _____
- Are you allergic to any foods? Please name them:

  _____
- Do you take any medications; prescribed and/or over the counter and/or vitamins, mineral, or herbal supplements?
  If so please list them on the back of this page to include regiment and dosage.
- Have you had any major operation? What Year(s)?
- Have you had any major accidents/injuries? What and When?
- Major Illnesses or Hospitalizations? What and When?

Do any of the conditions above aggravate a current health condition?

Personal Physical Program

Are you: Very Active_____Moderately Active_____Inactive_____

Any further insights/comment on your level of activity:

_____

Common Physical Activities

Mark the ones your do regularly

___Desk Sitting/car (how long)

___Jogging/Running

___Calisthenics

___Aerobics

___Swimming

___Weight Lifting

___Walking

___Other

___Standing (how long)

___Yoga/Tai Chi

___Hiking

Brandy Manguno brandy@yoga-llc.com (985) 502-7576

PLEASE PRINT

___Bike riding ___Horseback riding ___Tennis

Dietary Habits

Please put an (X) if in your regular daily diet;
Put (XX) by those you eat MOST often (more than once a day)

___Red meat	___Butter	___Coffee
___Fish	___Milk	___Black Tea
___Poultry	___Cheese	___Herbal Tea
___Vegetables	___Yogurt	___Alcohol
___Fruits	___Sugar	___Vitamins
___Raw Foods	___Honey	___Protein Supplements
___Grains	___Baked Goods	___Food Supplements
___Nuts	___Deserts	___Smoke Ciggs
___Seeds	___Eggs	
___Fermented Foods	___Seaweed/Kelp	

- What is it that you like most about your dietary habits?
  _____
- What would you like to change? _____
- Is there anything you eat/drink that you think exacerbates your condition and/or makes it worse? _____
- Is there anything you notice that makes it better? _____

Do you now undertake or have you undertaken a restricted diet? Please describe and indicate when?

_____

_____

Brandy Manguno brandy@yoga-llc.com (985) 502-7576

PLEASE PRINT

Past Health Problems

List all major health problems you have had in the past five years:

Problem Year

_____
_____
_____
_____
_____

Family History: Circle what applies

Diabetes Cancer Heart Issues Mental Illness Asthma Tuberculosis Gout Epilepsy Thyroid Problem Obesity Eating Disorder MS Other_____

Emotions and Feeling

Emotions and feelings are VERY IMPORTANT when undertaking a medicinal lifestyle change. Please be honest and open. You can elaborate on the back of this page.

- IS there an excess of stress in your life?
- What is causing the stress?
- Do you feel able to express your feelings and emotions?
- Are you satisfied with your job?
- If in a relationship, are you satisfied?
- Are you lonely?
- If there is one thing in your life you would like to change, what is it?
- Do you feel you have the ability or tools to change it?
- Are you a nervous type of person? What triggers this?
- Have you a "superman/Superwoman" complex?
- Do you sleep well?
- Do you dream? Can you recall them?

Brandy Manguno brandy@yoga-llc.com (985) 502-7576

PLEASE PRINT

- DO you often feel exhausted and fatigued?
- Is it easy to wake up in the morning?
- Which of these feelings dominate in your life (circle three):
  joy happiness anger sadness fear sympathy worry depression anxiety peace

Please indicate approximate dates and describe the nature of any traumatic experiences you have experienced in the past 7 years (divorce, loss of lover, loss of job, change of residency, accidents, injuries, deaths, etc.)

_____
_____
_____
_____

Brandy Manguno brandy@yoga-llc.com (985) 502-7576

PLEASE PRINT

FOR WOMEN ONLY

Contraceptive History: Circle all that have apply

BC Pills	Rhythm
IUD	Mucous Membrane
Diaphragm	Astrological
Condoms	Chemical Spermicides

Pregnancy History

List each pregnancy & dates you have had to include miscarriage and abortions.

_____
_____
_____
_____
_____

Circle any of the following problems that are currently happening in your life:

General

Vaginal Fibroid	Uterine Cysts	Endometriosis
Cervical Dysplasia	Pelvic Pain Where? How Long?	Anemia
Painful Intercourse	Swelling of hands and feet	Breast Lump
Vaginal Infection How long? What Type?		Breast Pain When in cycle?
Breast Cancer When Diagnosed?	Headaches Migraines	Genital Herpes
Vaginal Itching/Discharge	Difficulty Conceiving/Infertility	
General Fatigue, exhaustion	Pelvic Inflammatory Disease	

Brandy Manguno brandy@yoga-llc.com (985) 502-7576

PLEASE PRINT

Menstruating Women

Irregular Menstrual Cycles

Heavy Menstrual Bleeding

Bleeding between Menstrual Cycles

Painful Menstrual Cramps

Absence of Menstrual Cycle (how long?)

Absence of Menstrual Cycle

Dramatic mood swings around cycle

Menopause

Hot Flashes

Mild Mood Swings

Dramatic mood swings

Dry Vaginal Lining

Osteoporosis

Break through Bleeding

ERT Therapy

Other_____

Is there anything not listed above that are health concerns to you?

_____

_____

_____

_____

_____

Brandy Manguno brandy@yoga-llc.com (985) 502-7576