



4. Any significant traumas – (loss, deaths, etc.)

5. Do you currently have a therapist? Would you like for us to be in touch with your therapist while you are at FSR? If so, what is the name and contact information?



Relational

1. What are your general hopes for your time at Five Sisters Ranch?
2. Do you live alone or with others? If you live with others, what is your relationship to them?
3. Are you currently in a committed relationship? How long?
4. How do you identify your sexual orientation?
5. Do you have children? If so, how many and what are their ages?
6. Do you have relationships with your extended family? (Mom, Dad, siblings, etc.) How would you describe those relationships?



Biological

1. Does anxiety or mood changes interfere with your daily life?

2. Do you have any allergies?

3. Are you taking Medication? If so, please fill out the chart below

Medication Name	Dosage/Strength	Frequency	Prescribed by	Date Started

4. Are you currently experiencing grief, depression or sadness? Please explain.



5. Do you have a history of eating disorders?

6. When was your last menstrual cycle? Do you have any hormone issues we should be aware of?

7. Do you have any physical problems we should be aware of?

8. Do you have difficulty falling asleep, staying asleep or waking up?

9. When you think of yourself physically, what words or feelings come to mind?



Food Questionnaire

1. What would you like us to know about your relationship with food?
2. Do you have any medically necessary dietary restrictions? If so, what are they?
3. What is your “Go To Meal” for Breakfast?
4. If you drink coffee, what do you take in it?



Please fill out the following information for Physical Activities while at Five Sisters Ranch.

NAME:

D.O.B.

HEALTH: Please check everything pertaining to you so I will be more able to support you.

- Arthritis (what kind and where affected)
- Allergies (to what)
- Autoimmune conditions (i.e. chronic fatigue syndrome)
- Balance difficulty
- Breathing difficulty
- Broken bones (within 1 year)
- Birth of baby (within 6 months)
- Cancer (what kind and where)
- Depression
- Diabetes

- Epilepsy
- Gastro intestinal conditions
- Hearing difficulty
- High or low blood pressure
- Joint injuries or instability
- Menstruation conditions
- Neck or Spinal injuries
- Nerve disorders (i.e. Parkinson's)
- Post-traumatic stress disorder
- Pregnant
- Surgery (within 1 year or more if still affected)

If you think necessary, any additional explanation of checked conditions:

Have you practiced yoga before? What styles and for how long?

What do you typically do for exercise?