Yoga Intake Form

Today's Date: _____

Last Name: _____

First Name: _____M.I.:_____

Age:_____ Date of Birth: _____

Gender: _____

Street Address:

_____

_____ City: _____

State: _____ Zip code: _____

EMAIL ADDRESS_____

phone: _____

Ok to leave a message? _____

Name of emergency contact:

_____Relationship to you:

_____

Address:_____

_____ Home Phone:

_____Cell/Work Phone:

_____

Referral Source (how you heard about me!):

_____

_____

Health Information

*Please note: Any health information you share with me will be held in the strictest confidence. Sharing this information will help me to better serve you. I respect your privacy and your personal choice in sharing or not sharing information. That is your choice. Information withheld may prevent me from serving you in the best possible way.

Please answer the following questions using: 5 -Excellent, 4 - Good, 3 - Average, 2 - Poor, 1 - Failing

How would you currently rate your physical health? _____
How would you currently rate your mental health? _____
How would you currently rate your spiritual health? _____ (if does not apply to you, please use N/A)

Please list current symptoms (reason you are here) and circle those you currently find most bothersome:

_____

_____

_____

_____

_____

_____

_____

_____

Medical Information

Do you now have, or have you had in the past, any of the following? Circle all that apply:

Asthma
Allergies Headaches Brain Injury Epilepsy/Seizures

Digestive Disorders

Cancer
Diabetes
Breathing Problems Immune System Problems Heart Disease
High Blood Pressure Vision Problems
Hearing Problems Arthritis

Urinary Disorders Tuberculosis
Thyroid Disorder
Multiple Sclerosis
Chronic Fatigue Syndrome Fibromyalgia

Pregnancy (how many)_____ Complications?_____

_____

Serious Accident Surgery
Other _____

_____

Are you currently under the care of a Doctor or other medical health professional? _____ Name of Primary Care Physician: _____

Name of Specialist Physician: _____

Please list any prescription medications you are currently taking:

_____
_____
_____
_____
_____
_____

Please list any over the counter medications, vitamins, or herbal supplements you are currently taking:

_____
_____
_____
_____
_____

Do you currently exercise? _____ If yes, please indicate how many times per week: _____

What types of exercise do you like to do?

_____
_____
_____
_____

Have your ever sustained an injury that prevented exercise? If so, please explain:

Do you struggle with any areas of weakness and if so, where?

What do you hope to achieve with your yoga practice? Do you have any personal goals for your practice?

Is there anything else you would like to share or keep in consideration for you practice and/or private session?

I understand that a yoga practice is meant to be a part of a holistic lifestyle, and is not intended to diagnose or prevent disease. I will honor my body, and take appropriate care. I will listen and be open to modifications as they may be offered, if they seem to be in best interest of my body and wellbeing. I recognize that I am ultimately responsible for my wellbeing and for honoring my own limits.

_____ _____

Name Date