Essential
Yoga Therapy

**Client intake form**

This confidential information will help your instructor become aware of your specific needs when you work together.

Name: _____Date:_____

Address: _____

Telephone: _____ Email: _____

Date of Birth _____ Occupation: _____

Referred by:_____

**Do you have or have you had:**

___ High blood pressure
___ Glaucoma
___ Osteoporosis
___ Seizures
___ Diabetes
___ Rheumatoid arthritis
___ Anemia
___ Heart problems
___ Asthma
___ Other breathing problems
___ Dizziness, vertigo or loss of balance
___ Unexplained falls or fractures
___ Hearing difficulty
___ Hernia/rupture
___ Unstable/ “trick” joint(s)
___ Joint dislocation
___ Metal implants/artificial joints
___ Bladder or bowel control problems
___ Pinched nerves or disc problems
___ Cancer
___ Broken bones
___ Allergies

___ Blood thinners

___ Neurological diseases

___ Headaches

___ Vision difficulties

___ Chest pain

___ Shortness of breath

___ Night sweats

___ Joint swelling

___ Traumatic auto accidents

___ Major surgeries

**Other chronic conditions (Women only):**

___ Hysterectomy

___ Menopausal challenges

___ Caesarian delivery

___ Early termination of menses

**Are you pregnant?**

Yes No

**Please check if any of the following that apply in:**

____Back problems

____ Hernia

____ Joint Problems

____ Epilepsy

____ Fibromyalgia

____ Arthritis

____ Low Blood Pressure

____ Hypoglycemia

____ Chronic Fatigue

____ Anxiety/Depression

What is your predominant reason for seeking yoga therapy at this time?

Please list any recent surgeries:

Medications & supplements you are currently taking:

THIS IS VERY IMPORTANT! Please list any other health or medical condition below that you believe may be helpful to your instructor and any precautions that should be taken to ensure your well-being.

**Client's Notes:**

1. Have you experienced other health problems or challenges in your life?

2. Do you experience pain in any part of your body – on occasion, acute or chronic?

3. Tell me a little about your lifestyle? Diet? Exercise program? Do you smoke or drink?

4. How is your breathing?

5. How would you describe your energy levels?

6. Would you describe your overall energy as stable or quite variable?

7. How is your stress level?

8. What types of situations trigger stress or bring it on for you?

9. What are some of the ways you find most effective for releasing stress?

10. Do you awaken from sleep feeling rested? Do you fall asleep easily?

11. How do you have fun in your life?

12. How well do you feel you nourish yourself – with food, love and laughter?

13. How would you describe your state of mind most of the time?

14. How would you describe your spiritual or religious life?

**Yoga History**

1. What is your experience with Yoga, meditation or other spiritual practices?

2. How often do you practice and is your practice regular?

3. What have you found most beneficial from these practices?

4. What have you found most difficult or challenging?

5. Have you had any previous Yoga injuries? How did they happen?

6. What do you hope to get out of Yoga practice? What is your main goal for Yoga practice?

7. Do you have any other comments/concerns?