



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:

- | | |
|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Unexplained falls or fractures |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hearing difficulty |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Hernia/rupture |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Unstable/ "trick" joint(s) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Joint dislocation |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Metal implants/artificial joints |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bladder or bowel control problems |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Pinched nerves or disc problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Other breathing problems | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Dizziness, vertigo or loss of balance | <input type="checkbox"/> 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 :

☐ Hysterectomy

☐ Menopausal challenges

☐ Caesarian delivery

☐ Early termination of menses

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

Are you pregnant?

Yes No

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?