Health Info Intake

Please print when completing the information below. This information is kept confidential and is used only to design the yoga therapy sessions. If you have had recent surgeries or have an acute injury, please obtain clearance from your physician to do exercise and find out if there are any specific activities to avoid. Thank you and we look forward to helping you.

Name: _____

Email: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____ **Best phone #(s) :** _____

In an emergency, please call (name / relationship):

_____

Emergency Phone #(s): _____

Health Questions

1. Do you smoke? ◉ ○ If yes, how long? _____

2. Do you take prescription medication(s)? Yes ◉ or No ○

If Yes, please list and for what: (you can also print a list from your online medical chart, if applicable)

3. Do you have any allergies? If yes, please list. Include any sensitivity to essential oils.

4. Have you experienced or witnessed a past traumatic event that continues to impact your well-being? If yes, please describe history, severity, and/or limitations.

5. Do you have any condition that can cause dizziness? If yes, please describe history, severity, and/or limitations.

6. Do you have back pain? If yes, please describe history, severity, and/or limitations.

7. Do you have knee pain? If yes, please describe history, severity, and/or limitations.

8. Do you have shoulder pain? If yes, please describe history, severity, and/or limitations.

9. Do you have previous injuries that affect your activities? If yes, please describe.

10. Do you have previous surgeries? If yes, please describe.

11. Do you have a history of high blood pressure or blood clots? If yes, please describe.

12. Do you have asthma, COPD, or emphysema? If yes, please describe.

13. Do you have diabetes? If yes, please describe.

14. Do you have a heart condition, e.g., angina, high or low blood pressure, heart attacks, TIA or stoke? If yes, please describe.

15. Do you have any difficulty sleeping? If so, please describe.

16. Have you been diagnosed with any mental health conditions? If yes, please list conditions and indicate whether or not you are in treatment with a therapist and/or psychiatrist.

17. Do you have any other health conditions not listed? If yes, please describe.

18. Please add any additional valuable information:

19. Are you exercising or playing sports now? If yes, how many hours per week and what activities?

20. Are you pregnant? Yes, No, N/A. If yes, when are you due? ◉ ○ _____

21. On a scale of 0-10, how would you rate your level of pain over the past month, if any? Circle one

0 1 2 3 4 5 6 7 8 9 10

◉ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

22. On a scale of 1-10, how would you rate your level of stress over the past month, if any? Circle one

0 1 2 3 4 5 6 7 8 9 10

◉ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

23. What are your goals for a yoga practice? These can change over time and we will check in routinely.

Signature of participant: _____ **Date:**

If the participant is **under** the age of **18**,

Signature of **Parent/Guardian:** _____

Print Name: _____ **Date:**