Namaste Centered
YOGA THERAPY

Intake Form

It is my intention to create a safe and well-balanced yoga experience for you. Please answer the following questions honestly and to the best of your ability. Your responses here, as well as all of our interactions during yoga therapy, are kept in confidence between the client/student and the yoga therapist.

Name _____ Today's Date _____

Address _____

_____

Date of Birth _____ Contact information:

Occupation _____ Email _____

Phone _____

Referred by _____ Emergency contact:

Name _____

Phone _____

What would you most like to achieve through Yoga Therapy?

_____

_____

_____

Any secondary goals? _____

Please describe any previous experience with yoga, meditation, or any other types of stress management.

_____

_____

_____

How would you describe your energy level on average?

___ High ___ Good ___ Variable ___ Low ___ Very Low

How would you describe your sleep patterns?

___ Sound Sleeper ___ Light Sleeper ___ Difficulty Getting to Sleep ___ Difficulty Staying Asleep

Average hours sleep per night: _____

Are you currently managing a diagnosed health condition? Please describe.

_____

_____

Are you under the care of a medical professional or other health care provider? _____

Please list any prior injuries, hospitalization or surgeries.

_____

_____

_____

Do you have a history of any of the following conditions? (check all that apply)

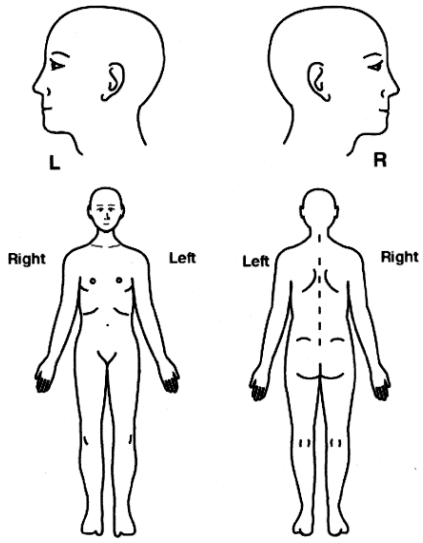
- ○ Allergies/Asthma
- ○ Anxiety
- ○ Cancer - _____
- ○ Circulatory Problems
- ○ Covid-19/Long Covid
- ○ Depression
- ○ Diabetes
- ○ Dizziness/Vertigo
- ○ Headaches
- ○ Heart Disease/Condition
- ○ High/Low Blood Pressure
- ○ Infectious Disease
- ○ Insomnia
- ○ Muscular Injuries
- ○ Osteoarthritis
- ○ Pregnancy/Delivery Complication
- ○ Respiratory Disease
- ○ Rheumatoid Arthritis
- ○ Spinal/Skeletal Injuries
- ○ Stroke

Are you currently experiencing any physical pain? If so, please describe below.

_____

_____

_____



Place an "X" on the figures to the left to indicate areas where you are experiencing pain.

When did symptoms first occur? _____

Is your pain constant or intermittent? _____

What increases your pain? _____

_____

What alleviates your pain? _____

_____

What best describes your pain (check all that apply):

___ Burning

___ Stabbing

___ Dull/Aching

___ Other _____

Describe any concerns, observations or recent changes regarding your cognitive function, emotional state, or other mental health symptoms.

_____

_____

_____

_____

If needed, please describe any other relevant issues you feel might limit your ability to participate in yoga therapy.

_____

_____

_____

Briefly describe your typical day, including home life. Do you have a regular schedule or does it vary? Are you alone or with others? Sitting, standing, driving, etc?

Do you currently have any hobbies/leisure activities, and if so, how much time you spend participating?

Do you exercise or participate in sports (if not listed above), and if so, how often?

How would you describe your current level of stress?

Have there been any recent events that may have contributed to or alleviated your stress? If so, please describe.

Do you currently have effective strategies for managing or releasing your stress?

Briefly describe your diet and nutrition.

What habits would you like to cultivate in your life? Are there any habits you would like to change?

Do you feel you have a support system in place that can help you reach your goals? What obstacles do you see in your life that might keep you from achieving your goals?

What gives you the greatest joy?

Do you feel as if you have a life purpose or mission?

Please describe any spiritual or religious dimension of your life.