New Yoga Client Intake and Health History Form

Name: ____

Preferred pronouns: ____

Address: ____

Phone number: ____

Email: ____

Occupation: ____

Emergency contact: ____

Have you practiced yoga before? ____ Yes ____ No

If yes, how often do you practice yoga? ___ Once in a while ____ once a week _____ daily

Which styles of yoga have you practiced before? Check all that apply.

Ashtanga ___

Hot ___

Bikram ___

Kundalini ___

Yin yoga ___

Hatha ___

Iyengar ___

Vinyasa ___

Power yoga ___

Not sure ___

Rate the following, 1 out of 10 (10 being high):

Daily activity level _____

Daily stress level _______

What are your personal health goals for taking yoga? Check all that apply.

Weight loss ___

Strength ___

Stress relief ___

Flexibility ___

Chest pain ___

Improve overall health ___

Address specific concerns ___

Alternative therapy ___

Knee pain ___

Balance/inner peace ___

Other/explain more:

____

____

____

What aspects of yoga are you most interested in? Check all that apply.

Physical postures ___

Yoga philosophy ___

Breath work/pranayama ___

Meditation ___

Please mark all that apply:

Arthritis ___

Osteoporosis ___

Muscle pain ___

Muscle weakness ___

Scoliosis ___

Bulging disc ___

Generative disk ___

Back pain/injury ___

Anemia ___

Sciatic ___

Diabetes ___

Asthma, shortness of breath ___

Seizures ___

Stroke ___

Heart conditions, chest pain ___

Anxiety ___

Depression ___

High blood pressure ___

Low blood pressure ___ Cancer ___

Surgery ___ Pregnancy ____

Knee pain/injury ___

Other/explain more:

____

____

____

Are you currently taking any medications: ____ Yes No ____

If yes, list names and reasons for medications:

____

____

____

I authorize the collection and use of the above personal information as is required for therapeutic treatment and related administrative purpose. I understand that all my personal information is confidential and will not be released without my signed consent.

I understand that yoga is not a substitute for medical attention, examination, diagnosis or treatment. Yoga is not recommended and is not safe under certain medical conditions. By signing, I affirm that a licensed physician has verified my good health and physical condition to participate in yoga classes, offered by Intentions Yoga. In addition, I will make my yoga instructor aware of any medical conditions or physical limitations before class. If I am pregnant, become pregnant or am post-natal or post-surgical, my signature verifies that I have my physician's approval to participate. I also affirm that I alone am responsible to decide whether to practice yoga and participation is at my own risk. I hereby agree to irrevocable release and waive any claims that I have or may have hereafter against Intentions Yoga.

Name: ____________________________

Signature: _________________________

Date: _____________________________

By filling out this form you agree to be added to the mailing list of Intentions Yoga. You have the option to unsubscribe at any time. Thank you.

Please note that a 24 hour cancellation policy is in place