River Warrior Yoga

Intake Form

Name:____Date:__________________________________

Phone number: (home)_________________________(cell)__________________________________

Special notations of best time/method to reach or not to call

____

Email:____

Emergency Contact: ____

What brings you here today?____

____

Primary Doctor:____

Specialized Physician or health care practitioners(s):___________________________________

____

List of any medications, supplements or related conditions:____________________________

____

____

Does your Physician or Health Care Provider know you will be doing yoga? Y N

Are there any movements that have been advised against or restricted?_______________

____

Do I have permission to contact this person(s) if necessary?____________________________

Surgeries- past & anticipated (type & date)____

____

If you have/had any of the following conditions; please circle past or current;

and briefly describe if applicable.

Allergies: past or current ____

Physical Impairments: past or current ____________________________________

Heart Problems: past or current ____

High/Low Blood pressure: past or current_________________________________

Arthritis: past or current____

Chronic Illness: past or current____

Chronic Pain: past or current____

Lung Problems: past or current____

Neck, Back, or Joint Problems: past or current___________________________

Diabetes: past or current, type & medication_____________________________

Headaches: past or current, type & usual solution_____________________

Cancer: past or current, type, any treatments or symptoms:_____________

____

Seizures or loss of consciousness: past or current______________________

Thyroid Condition: past or current____

Physical Trauma: (i.e. car, falls, ect)______________________________________

Mental Health Conditions, please describe:________________________________

Do you smoke cigarettes? If so, what types, and how often?_____________

Do you consume alcohol? If so, what type and how often?_______________

Past or Present illicit drug use? If so, what types, and how often?_______

(Please be honest, this is confidential.)____________________________________

____

Describe sleep patterns:____

Describe diet & digestion:____

Do you a religious or spiritual beliefs or practices?_____________________________________

One a 1-5 scale, 1 being the least, 5 being the highest amount;

Are you in any physical discomfort/pain? (1-5 and describe)_________________________

____

How stressed are you on a day to day basis? (1-5 and describe)______________________

____

Contributing Factors:____

What do you do for stress management?____

Describe your overall health?____

Do you exercise? If so what type, how long and how often?____________________________

____

Have you ever done yoga? Type? How often? Things you did or did not find useful?

____

What do you hope to accomplish through yoga/yoga therapy? (Goal(s)______________

____

Additional Concerns:____

How much time are you willing to commit outside of this/these sessions?____________

____