Yoga Therapy Intake Form

Name: **Age:** **Date:**

_____ _____ _____

email: **Phone:**

_____ _____

Which do you prefer for contact, phone or email?
Is it permissible to leave a message on your phone?

Occupation:

What are your current reasons for seeing a yoga therapist? Do you have a goal for our time together?

List your current & previous health conditions? Please include medical diagnoses, surgeries, accidents, injuries, etc., and approximate dates.

How long has your current health issue been going on?
1 month __ 3 months __ 6 months __ 12 months __ Over a year __ Chronic __

Who else are you currently seeing for your health concerns or general health promotion? How often do you see them?

Would you like me to share your information with your healthcare providers?
If so, please provide their names, addresses and telephone number below.

_____

_____

Describe the areas of discomfort and/or pain in your body. Try to describe where they are located and type/degree of discomfort. Rate your level of pain, using a scale of 1 to 10, 10 being the highest level of pain or discomfort.

Area of discomfort/pain _____ Scale ____
Area of discomfort/pain _____ Scale ____
Area of discomfort/pain _____ Scale ____

Area of discomfort/pain _____ Scale ____
(if you need more room use the back of the sheet)

What relieves your pain? What increases your pain?

What functional movements and tasks are difficult for you? Reaching? Bending? Picking up? Twisting? Sitting for long periods of time? Walking up stairs? Standing?

What are your favorite physical movements? Least favorite? Do you have a regular exercise program? Please describe?

Are you aware of any imbalances in your body" Are you satisfied with your posture? Where do you hold tension in your body?

Please check off items below that apply to you on a chronic or recurrent basis at the present time or within the past year:

I. Digestion

___Heaviness after eating
___Bloating after eating
___Sleepy/low energy after eating
___Belching
___Nausea
___Vomiting
___Burning indigestion
___Pain in stomach, intestines or rectum
___Excessive intestinal gas
___Gallbladder discomfort
Hunger Level: ____Variable ____Strong ____Average ____Low

II. Elimination

___Constipation (<1 BM / day)
___Diarrhea
___Alternate between diarrhea & constipation
___Difficult/painful bowel movements
___Hemorrhoids
___Blood in stools
___Mucus in stools
___Unusual color in stool
___Stools have odor
___Food particles in stool
Stool consistency: ___loose ___soft ___hard ___pellets ___dry
Stool density: ___float ___sink ___scatter
Stool color: ___clay color ___brown ___other _____
Number of bowel movements per day_____

Diet: What types of foods are eaten on a regular basis? (at least twice/week)

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

How much water do you drink per day? _____cups / ounces

How many cups of caffeinated beverages per day?_____Type(s) coffee / tea / soda
How many glasses of alcohol per day?_____Type(s) beer / wine / hard liquor

How many cups of non-caffeinated beverages do you drink per day? _____
Type(s) of beverage: milk / juice / herbal tea / other _____

Please list your current medications vitamins, herbs and supplements.

Substance	Dosage	Taken for how long?	Reason

Do you or have you ever smoked?

Is your daily schedule regular or does it change from day to day?

Briefly state your daily routine. In percentages how much of your day is spent with the following:

- **Sitting**
- **Driving**
- **Standing**
- **Desk work**
- **Lifting**
- **Lying**

Please describe your overall energy level. Does it fluctuate or stay consistent? When are you most energized, least energized?

Do you have any difficulty breathing? Do you notice changes in your breath when you become upset or agitated?

Describe your sleep habits.

When do you normally turn off all digital media?

What are your perceived stress levels – low, moderate, high? Describe the possible stressors in your life?

Check any of these emotions that you feel on a regular basis. Are there places in your body where these feelings tend to dwell when they come up? Please list.

Psychology

___Worry	___Irritable	___Lethargy
___Anxiety / Fear	___Anger / Rage	___Sadness
___Overwhelm	___Aggressive	___Depression
___Spaced Out	___Jealousy / Envy	___Greediness
___Insomnia	___Critical / Judgmental	___Over attachment
___Self-destructive	___Intense / Sharp	___Procrastination
___Indecisive	___Tension	___Controlling

Other: _____

Are there emotions you have difficulty feeling, expressing or validating?

Are your personal relationships healthy and nurturing? What changes would you like to see in these relationships or socially?

Is your career and/or schooling nurturing and supportive? What changes would you like to see in your career or schooling?

What life challenges are your currently facing? Do you keep running up against the same problems/situations in life?

Do you have a spiritual practice?

Are there habits that you would like to change?

Have you considered or are you already volunteering your time or talents?

What aspects of your life give you the most joy and pleasure? What do you feel is your life's calling?

Where do you see yourself in 1 year, 5 years and 10 years?

If you could change one thing, what would it be?

Describe a natural scene you can easily visualize which is healthy, inspiring, joyful and grounding. What sounds, fragrances, colors, feelings inspire you in this scene?

How much time (each day/week/month) can you devote to your own personal yoga practice?

When you are available for yoga therapy sessions (days and times)?

Thank you for taking the time to complete this form to the best of your ability.
Please return by email to diane.kistler@gmail.com.

Waiver and Liability Form

Diane Kistler Yoga Therapy
138 Winding Way
Telford, PA 18969

Client Registration, Agreement of Release and Waiver of Liability

Please Print Clearly

Name: _____

Address: _____

City:_____ State: _____ Zip Code: _____

Home Phone: ( )_____-_____ Cell Phone: ( )_____-_____

Email: _____

What are your goals in taking yoga at this time?

_____

_____

Yoga Background: _____

Emergency Contact: _____ Phone: ( )_____-_____

Injuries/Medical History:

_____

_____

_____

_____

if more space is needed, please use the back of this form

Please Read Carefully:

By my participating in a yoga therapy program with Diane Kistler Yoga Therapy, I agree to take full responsibility for not exceeding my limits in practice of yoga and for any injury that I might suffer in the practice of yoga. It is my responsibility to ascertain that there is no medical reason to prevent my participation and consult with a physician prior to and regarding my participating in a yoga therapy program. Yoga is not a substitute for medical attention, examination, diagnosis or treatment. In consideration of Diane Kistler's offering of yoga therapy, I waive any claim that I might have at any time for injury of any sort against Diane Kistler or any person or entity in any way involved therewith. I have carefully read the release, fully understand and agree to the above.

Signature of Client: _____ Date: _____

If client is under the age of 18: As legal guardian or parent of _____, I consent to the above terms and conditions.

Signature of Parent or Guardian

_____ Date: _____