

YOGA CLIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a student of
This form is used to collect information about new students and for internal purposes only. The information you provide is confidential and will be treated accordingly.

STUDENT GENERAL INFORMATION

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Occupation: _____

Emergency Contact Name: _____ -Phone: _____

Referred by: _____

YOGA EXPERIENCE/GOALS

Have you practiced yoga before? Yes No

-If yes, when was your last class/practice? _____

How often do you practice yoga? Never Daily Weekly Monthly

What style of yoga have you practiced most frequently? (check all that apply)

- Hatha Ashtanga Vinyasa/Flow Iyengar Power Anusara Bikram/Hot
 Forrest Kundalini Gentle Restorative Yin Other: _____

What are your goals/expectations in yoga? What benefits do you seek? (check all that apply)

- Strength training Flexibility Balance Stress relief Address health concern
 Alternative therapy Improve fitness Weight management Increase well-being
 Injury rehabilitation Positive reinforcement Other: _____

What are your personal yoga interests? (check all that apply)

- Asana (postures) Pranayama (breath work) Meditation Yoga philosophy
 Eastern energy systems Other: _____

LIFESTYLE AND PHYSICAL HISTORY

How do you rate your current level of physical activity?

Sedentary/Very inactive Somewhat inactive Average Somewhat active Very active

On a scale of 1-10, (1 being the lowest and 10 being the highest), how would you rate your level of stress? _____

Check the conditions that have affected your health either recently or in the past.

- | | | |
|--|--|---|
| <input type="checkbox"/> Broken/dislocated bones | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Muscle strain/sprain | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis/bursitis | <input type="checkbox"/> Anxiety/depression | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Disc problems | <input type="checkbox"/> Asthma/short breath | <input type="checkbox"/> Heart conditions/chest pain |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Auto-immune condition
(e.g., AIDS, lupus) |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pregnancy | |
| <input type="checkbox"/> Diabetes type 1 or 2 | (EDD _____) | |

Are you currently taking any medications? Yes No

-If yes, please list the names and reasons for the medications:

Is there any other information you would like to share?

ACKNOWLEDGMENT

By attending this class, I affirm that I am solely responsible for my health and well-being, as well as my decision to practice yoga, a program of physical exercise. I agree to inform my yoga instructor of any activities or movements which I feel could cause injury to myself. I understand that yoga/meditation/breathing techniques are not recommended and are not safe under certain medical conditions. I do not have any physical conditions or disability that would limit my participation or preclude an exercise program. _____ shall not be held liable for any injury, loss, or damage to property and/or persons sustained during or as a result of participation in these classes. I agree to listen to my body and monitor myself during every class session.

Student signature: _____ Date: _____

Print name: _____