



CLIENT INTAKE – HEALTH HISTORY FORM

Name _____ Date _____

Email _____ Receive Our Newsletter? ☐ Yes ☐ No

Home Phone _____ Cell Phone _____

Mailing Address _____

Emergency Contact Name _____

Relationship to You _____ Phone _____

YOGA EXPERIENCE & GOALS

Have you ever practiced yoga before? ☐ Yes ☐ No

If yes, approximate date of last practice _____

How often do you practice yoga? ☐ Daily ☐ Weekly ☐ Monthly

Styles of yoga practiced (check all that apply)

- | | | | | | |
|---------------------------------|-----------------------------------|--------------------------------------|----------------------------------|--------------------------------|---------------------------------|
| ☐ Hatha | ☐ Asthanga | ☐ Vinyasa | ☐ Iyengar | ☐ Power | ☐ Bikram |
| ☐ Gentle | ☐ Yin | ☐ Restorative | ☐ Other | | |

Meditation (type) _____ Chanting _____

What are your goals/expectations for your yoga practice? What benefits are you looking for?
(check all that apply)

- | | | | |
|--|--------------------------------------|---|--|
| ☐ Strength Training | ☐ Flexibility | ☐ Health Improvement | ☐ Balance |
| ☐ Stress Relief | ☐ Body Image | ☐ Weight Loss | ☐ Emotional Balance |

Address Health Concerns _____



YOGA EXPERIENCE & GOALS

Please review this list and check those conditions that have affected your health either recently or in the past. Your health information is kept confidential and will never be shared.

- | | | |
|--|--|---|
| ☐ Broken/Dislocated Bones | ☐ Scoliosis | ☐ Diabetes Type 1 or 2 |
| ☐ Asthma, Short of Breath | ☐ Pregnancy (if pregnant EDD) | ☐ Heart Conditions, Chest Pain |
| ☐ Muscle Strain/Sprain | ☐ Numbness, Tingling | ☐ High/Low Blood Pressure |
| ☐ Auto-immune condition | ☐ Surgery | ☐ Osteoporosis/Osteopenia |
| ☐ Insomnia | ☐ Cancer | ☐ Back or Disc Problems |
| ☐ Anxiety/Depression | ☐ Other/Explain: _____ | |
-

Please select any of the following symptoms you have had in the recent past or are experiencing now:

- | | | |
|---|---|---|
| ☐ Night Pain | ☐ Stroke | ☐ Severe Psychological Issues |
| ☐ Loss of sensation in an area of the body | ☐ Unremitting pain | ☐ Multiple joint complaints, especially in the morning |
| ☐ Joint deformity | ☐ Joint Noise | ☐ Joint Locking/Instability/Dislocation |
| ☐ Menstrual Changes | ☐ Unexplained Weight Loss/Gain | ☐ Loss of Consciousness |
| ☐ Gait/Balance Changes | ☐ Visual/Speech Impairment | ☐ Motor Control Problems |
| ☐ Cardiovascular Complaints | ☐ Positional Headaches – such as when bending over or leaning back | ☐ Unilateral Complaints (one side of the body only) |
| ☐ Night Sweats | ☐ Bowel and Bladder Control Problems | ☐ Recent Trauma, Such as a Car Accident, Fall, etc. |
| ☐ Swelling | ☐ Increased Pain or Radicular (shooting) signs | |

Please explain any of the items checked:
