



# The Yoga Barn

## New Client Intake Form

This confidential information will help your instructor become aware of your specific needs when you work together.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_

E-mail: \_\_\_\_\_ Fax: \_\_\_\_\_

Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

### Do you have or have you had:

- |  |  |
|--|--|
| <input type="checkbox"/> High blood pressure                   | <input type="checkbox"/> Headaches                 |
| <input type="checkbox"/> Glaucoma                              | <input type="checkbox"/> Vision difficulties       |
| <input type="checkbox"/> Osteoporosis                          | <input type="checkbox"/> Chest pain                |
| <input type="checkbox"/> Seizures                              | <input type="checkbox"/> Shortness of breath       |
| <input type="checkbox"/> Diabetes                              | <input type="checkbox"/> Night sweats              |
| <input type="checkbox"/> Rheumatoid arthritis                  | <input type="checkbox"/> Joint swelling            |
| <input type="checkbox"/> Anemia                                | <input type="checkbox"/> Traumatic auto accidents  |
| <input type="checkbox"/> Heart problems                        | <input type="checkbox"/> Major surgeries           |
| <input type="checkbox"/> Asthma                                | <input type="checkbox"/> Other chronic conditions? |
| <input type="checkbox"/> Other breathing problems              | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Dizziness, vertigo or loss of balance |  |
| <input type="checkbox"/> Unexplained falls or fractures        |  |
| <input type="checkbox"/> Hearing difficulty                    |  |
| <input type="checkbox"/> Hernia/rupture                        |  |
| <input type="checkbox"/> Unstable/ "trick" joint(s)            |  |
| <input type="checkbox"/> Joint dislocation                     |  |
| <input type="checkbox"/> Metal implants/artificial joints      |  |
| <input type="checkbox"/> Bladder or bowel control problems     |  |
| <input type="checkbox"/> Pinched nerves or disc problems       |  |
| <input type="checkbox"/> Cancer                                |  |
| <input type="checkbox"/> Broken bones                          |  |
| <input type="checkbox"/> Allergies                             |  |
| <input type="checkbox"/> Blood thinners                        |  |
| <input type="checkbox"/> Neurological diseases                 |  |

### Women only:

- Hysterectomy
  - Menopausal challenges
  - Caesarian delivery
  - Early termination of menses
- Are you pregnant? Yes No

**Additionally, please check if any of the following apply:**

Back problems \_\_\_\_

Hernia \_\_\_\_

Joint Problems \_\_\_\_

Epilepsy \_\_\_\_

Fibromyalgia \_\_\_\_

Arthritis \_\_\_\_

Low Blood Pressure \_\_\_\_

Hypoglycemia \_\_\_\_

Chronic Fatigue \_\_\_\_

Other:

Recent Surgery:

Medications & supplements you are currently taking:

**THIS IS VERY IMPORTANT**

Please mention any other health or medical condition that you believe may be helpful to your instructor and any precautions that should be taken to ensure your well-being.

**Client's Notes:**

1. Have you experienced other health problems or challenges in your life?
2. Do you experience pain in any part of your body – on occasion, acute or chronic?
3. Tell me a little about your lifestyle? Diet? Exercise program? Do you smoke or drink?
4. How is your breathing?
5. How would you describe your energy levels?
6. Would you describe your overall energy as stable or quite variable?
7. How is your stress level?
8. What types of situations trigger stress or bring it on for you?
9. What are some of the ways you find most effective for releasing stress?

10. Do you awaken from sleep feeling rested? Do you fall asleep easily?
  
11. How do you have fun in your life?
  
12. How well do you feel you nourish yourself – with food, love and laughter?
  
13. How would you describe your state of mind most of the time?
  
14. How would you describe your spiritual or religious life?

### **Yoga History**

1. What is your experience with Yoga, meditation or other spiritual practices?
  
2. How often do you practice and is your practice regular?
  
3. What have you found most beneficial from these practices?

