All information given in this questionnaire is strictly confidential.

Today's Date: _____

CURRENT INFORMATION

Full Name: _____ Date of Birth: _____

Age: _____ Gender Identity: _____ Email: _____

Emergency Contact:_____ Phone: _____

Occupation: _____

CONCERN(S)

What is the primary concern or goal for today? Have you had this in the past? If so, describe.

_____

_____

Please describe when the above began. What makes it better/worse? Its severity? Anything else…

_____

_____

_____

Is it? (circle one) getting worse getting better coming and going staying the same.

Please list other current concern(s):

Complaint Since Cause (if known)

_____

_____

_____

_____

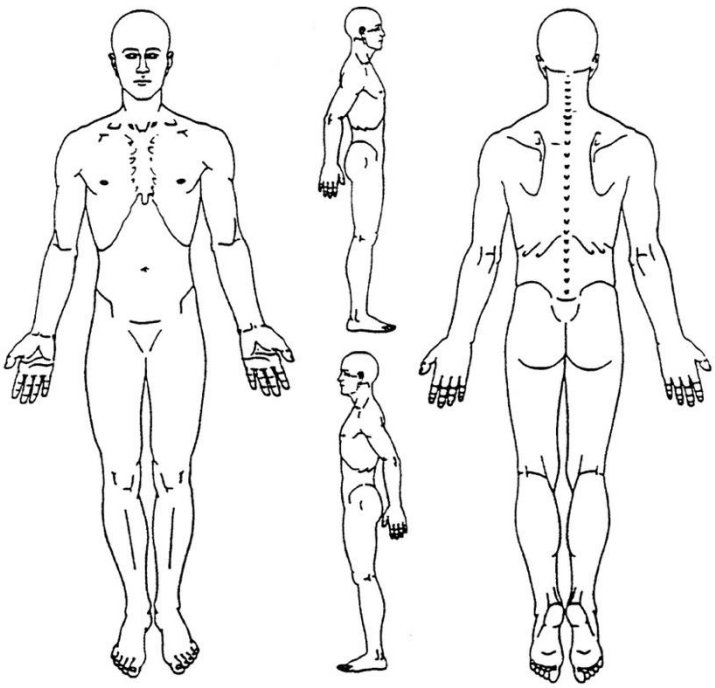
Do you have any specific body discomfort? If yes, please describe:

_____

_____

_____

If relevant to your visit, please circle any problem areas in the drawing and if possible, write a word to indicate the type of sensation or sensations there, such as tight, burning, numb, sharp pain, etc.



Do you perform any repetitive movement in your work, sport, yoga practice, recreation, home care, or other activities?

_____

_____

Are you seeing healthcare or other service providers for this issue/condition? (acupuncturist, physical therapist, massage practitioner)? (Yes/No) If so what is the diagnosis and what treatment if any have your tried?

_____

_____

Have you made any observations about your body, energy, mental or emotional life, beliefs and life philosophy in relation to this concern that you would like to share?

_____

_____

_____

In what way(s) do you think yoga movement therapy can be of help to you?

_____

_____

LIFESTYLE

How many hours do you work each week? _____ Do you like your work? _____
Does your work stress or exhaust you? (Yes/No)
Do you generally get enough sleep? (Yes/No) Please describe: _____
Living Status: _____ Children: _____
(single/married/partner/divorced/widowed)

Are you currently or have you recently gone through an unusually stressful life change or event?

(divorce, death in family, etc.)_____

_____

_____

What kind of diet do you eat?
___ Typical American ___Vegetarian ___Vegan ___Other:
Do you smoke cigarettes, cigars, marijuana? (Yes/No) If yes, list:_____
Do you drink alcohol? (Yes/No) If yes, how many drinks per week?_____
Do you use recreational drugs? (Yes/No) If yes, what and how often? _____

_____

What do you do to exercise and how often? (Ex. Walk 30 min/5 days a wk.)
_____

_____

What current or past sport, movement, dance, performance or art experience do you have?
_____

_____

What is your experience with yoga, meditation or similar eastern or wholistic practices?

_____

_____

_____

What are your biggest stressors? _____

Do you sit for long hours at a workstation, computer, and/or driving?
_____

_____

List allergies to medicines, foods and environmental factors:
_____

_____

List prescriptions or over-the-counter medications taken regularly:
_____

_____

List vitamins, minerals, herbal preparations, tonics, supplements, flower essences, cell salts, homeopathic remedies or the like taken regularly:
_____

_____

What do you do for fun and/or to relax?
_____

_____

HISTORY
List major illnesses and hospitalizations (operations, injuries/accidents and their dates):
_____

_____

_____

_____

_____

Have you ever been diagnosed with any of the following? If so, what year?

___Pneumonia	___Skin boils	___Obesity	___Rheumatic fever
___Tuberculosis	___Eczema	___Anemia	___Measles
___Asthma	___Psoriasis	___Blood transfusion	___Mumps
___Bronchitis	___Parasites	___Colitis	___Chicken pox
___Emphysema	___Jaundice	___Ulcer	___Polio
___High blood pressure	___Hepatitis	___Epilepsy/Seizure	___Whooping cough
___Low blood pressure	___Gallstones	___Mental breakdown	___Diphtheria
___Heart disease	___Kidney stones	___Arthritis	__Lyme's disease
___Drug reaction	___Bladder Infection	___Cancer	___Chronic Fatigue
___Migraine	___Hypoglycemia	___Syphilis	___fibromyalgia
___Hives	___Diabetes	___Gonorrhea	___Other:

Please list and briefly describe any conditions, medical or otherwise, that may prohibit or limit your practice of yoga stretches, movements, breathing, meditation, introspection, or relaxation:
_____

_____

_____

List ailments of immediate family and indicate if deceased.
Mother: _____

Father: _____

Siblings: _____

Is there anything else you would like me to know?

_____

_____

Practice Information, Consent and Waiver

Practice Information
Yoga Movement Therapy is dedicated to the promotion of personal growth, wellbeing, and the prevention of chronic illness and injury whenever possible. Yoga is an ancient science that may benefit a person at every level of their being. Yoga Movement Therapy utilizes the time-tested techniques, principles and practices of yoga to support and facilitate natural mechanisms of healing, improved functionality, and increased self-awareness.

All information is strictly confidential.

Consent

I, _____ (print), voluntarily consent to engage in Yoga therapy and participate at my own level of comfort, knowing I can decide to discontinue at any time. I understand that Yoga therapeutic methods are based on holistic principles and practices of Yoga - its science and philosophy, and western scientific data and are not, as yet, considered standard treatments in mainstream medicine. During Yoga sessions, I am aware I will engage in the activities designed for my concern. I agree to take responsibility by being mindful of what I can and cannot do and to inform my Yoga therapist of limitations, symptoms, pain, discomfort, or other concerns that occur or change at any point. I understand that Yoga involves both cognitive and physical elements and there is inherent risk when undertaking physical activity. I realize Yoga therapy is designed to benefit my concern, but that success is not be guaranteed. I acknowledge I must take an active role in performing the recommendations given for them to be affective.

I am aware that my Yoga therapist is not a licensed physician, and that Yoga therapy is complementary to licensed healing arts, and its practices are not currently licensed.

I understand that my Yoga therapist is a supervised trainee in a professional yoga therapist training accredited by the International Association of Yoga Therapists, which is the highest level of yoga expertise for therapeutic yoga practice acknowledged worldwide.

I acknowledge that it is my responsibility to consult with my physician and obtain his or her consent prior to beginning yoga therapy. I also understand I have been advised to consult a physician for any health problems if I have not done so. I recognize it is my responsibility to ascertain that there is no medical reason preventing me from any specific practice.

I realize that touching, guiding movement, awareness, or positioning my body may be necessary and I expressly consent to such physical contact. If I do not wish to be touched, I will initial the consent form here ( ) to notify the therapist, so a joint decision can be made about continuing the practice with this limitation.

Waiver

I hereby release, my yoga therapist, their mentorship supervisor, Dr. Jaime Stover Schmitt, Spanda® Yoga Movement Therapy, and all other sponsoring agencies when relevant from responsibility for any injuries I may sustain as a result of participation in this work.

I understand that I am encouraged to ask questions and discuss my progress with the therapist at all times, and that I have read the above, understand it, and engage in this practice of my own volition.

_____ _____

(Name) (Date)

_____

(Signature)