All information given in this questionnaire is strictly confidential.

Today's Date: _____

CURRENT INFORMATION

Full Name: _____ Date of Birth: _____ Pronoun: _____

Address: _____ Age: ____ Gender Identity: _____

City/State/Zip: _____ Phone: _____

CONCERN(S)

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

_____

_____

When did the above begin?

_____

If painful, how bad is the pain/discomfort on a scale of 1-10 with 10 being worse._____

Does anything make it better? Does anything make it worse?

_____

_____

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)

_____

_____

_____

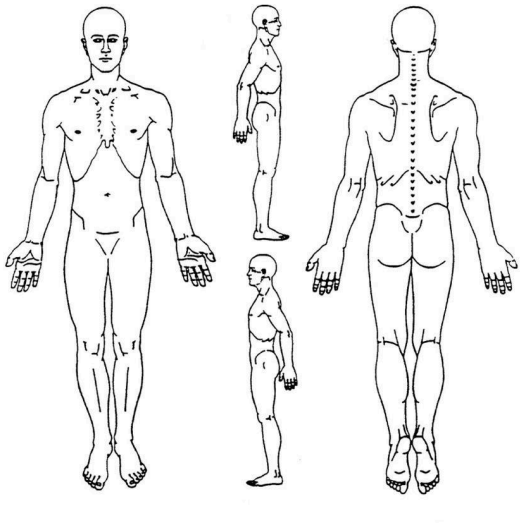
_____

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

_____

_____

Does it radiate or travel anywhere? _____



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

If the pain/discomfort radiates or travels, please indicate on the figure with the letter T.

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 treatments, if any, have your tried?

_____

_____

What else, if anything, are you doing for this? _____

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

_____

_____

_____

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

_____

_____

Please list current medications, supplements, or vitamins that you take.

_____

_____

LIFESTYLE

How many hours do you work each week? _____ Do you like your work? _____

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

_____

_____

Does your work stress or exhaust you? (Yes/No)
What are your biggest stressors? _____

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

_____

_____

What type of food do you typically eat?

_____

_____

Describe the times of day you eat, and are you sharing meals, eating with TV or internet, or while working?

_____

_____

How often do you have a bowel movement in a normal day or week?

_____

_____

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

_____

_____

Describe your sleep habits. How many hours per night? Easy or difficult to fall asleep? Wakefulness during the night? If so, at what time?

_____

_____

Emergency Contact Information

_____

_____

PRACTICE INFORMATION, CONSENT & WAIVER

Essential You Yoga Practice & Practitioner Information
Essential You Yoga is dedicated to the promotion of personal growth, well-being, 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 Therapy utilizes the time-tested techniques, principles and practices of yoga, mindfulness, Ayurveda, and Reiki to support and facilitate natural mechanisms of healing, improved functionality, and increased self-awareness.

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 the science and philosophy of yoga as well as western scientific data and are not, as yet, considered standard treatments in mainstream medicine.

During Yoga therapy 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 guaranteed. I acknowledge I must take an active role in performing the recommendations given for them to be effective.

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

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, 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.

I understand that I am entering into a confidential relationship, but that my therapist will abide by best practices and notify the appropriate authorities, such as law enforcement or emergency services, if there is reason to believe that I am at risk of harming myself or others, in accordance with Florida state law.

Waiver
I hereby release, my yoga therapist 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.

_____ _____
(Printed Name) (Date)

_____
(Signature)