YOGA THERAPY INTAKE FORM

Client Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

Emergency Contact Information:

Name: _____

Relationship: _____

Phone: _____

Health Information:

Current Medical Conditions (please list):

_____

Recent Surgeries, Injuries, or Hospitalizations:

_____

Medications (include dosage and frequency):

_____

Allergies (medications, food, environmental):

_____

Primary Care Physician Name and Contact:

_____

Lifestyle Information:

Occupation: _____

Exercise Frequency: _____

Types of Physical Activity:

_____

Dietary Habits / Restrictions:

_____

Stress and Mental Health:

Do you currently experience stress? (Yes/No) _____

If yes, please describe:

_____

Have you ever been diagnosed with a mental health condition? _____

If yes, please specify:

_____

Please indicate if you have any of the following conditions by marking yes or no beside each: heart disease, high/low blood pressure, seizures, osteoporosis, herniated discs, pregnancy, joint replacements, recent fractures, surgeries, or other relevant medical concerns.

☐	Yes - Heart disease	☐ No - Heart disease
☐	Yes - High blood pressure	☐ No - High blood pressure
☐	Yes - Low blood pressure	☐ No - Low blood pressure
☐	Yes - Seizures or epilepsy	☐ No - Seizures or epilepsy
☐	Yes - Osteoporosis	☐ No - Osteoporosis
☐	Yes - Herniated discs or back problems	☐ No - Herniated discs or back problems
☐	Yes - Pregnancy	☐ No - Pregnancy
☐	Yes - Joint replacements	☐ No - Joint replacements
☐	Yes - Recent fractures	☐ No - Recent fractures
☐	Yes - Recent surgeries	☐ No - Recent surgeries
☐	Yes - Other relevant medical concerns	☐ No - Other relevant medical concerns

Consent and Agreement:

I hereby affirm that the above information is accurate and complete to the best of my knowledge. I understand that yoga therapy is not a substitute for medical treatment, nor does it replace the need for professional medical care. I agree to inform my yoga therapist of any changes in my health status and understand that I may stop participation at any time. I release the yoga therapist from any liability arising from my participation in yoga therapy sessions.

CLIENT SIGNATURE

Signature: _____

Print Name: _____

Date: _____

YOGA THERAPIST SIGNATURE

Signature: _____

Print Name: _____

Date: _____

Privacy Notice:

All personal information collected in this form is confidential and will be used solely for the purpose of providing yoga therapy services. It will not be disclosed to third parties without your explicit consent, except as required by law.

Disclaimer:

Yoga therapy sessions are designed to complement conventional medical treatments and are not intended to diagnose, treat, cure, or prevent any disease. The client is responsible for consulting with their healthcare provider regarding any health concerns.