Confidential Yoga Therapy Client Information Form

Name: _____ Date:_____

Phone number: _____ Email:_____

Address:_____

Date of Birth:_____ Profession: _____ Referred by:_____

Emergency Contact:_____

Musculoskeletal	**Cardiovascular**	**Neurological**	**Endocrinological**
Neck/Back/Joint Pain or Trouble	High Blood Pressure	Seizure	Low Blood Sugar
Stiffness	Low Blood Pressure	Headache	HBS/Diabetes
Fibromyalgia	Heart Palpitations	Migraines	Thyroid Issues
Osteoporosis	Heart Murmur	Insomnia	**Gynecological / Urological**
Arthritis	**Circulatory**	Depression	Breast Issues
Accidents (Physical Trauma)	Bruise Easily	Anxiety	Possible Pregnancy
Overuse Syndrome (RSI)	Varicose Veins	**Gastrointestinal**	Positive Pregnancy (Which Trimester? ___)
Respiratory	Swollen or Painful Lymph Nodes	Diarrhoea	
Lung Issues	Poor Circulation	Constipation	Peri/Post-Menopausal (Please Circle)
Allergies		Other Digestive	Men: Prostate Issues

Please provide further information on any conditions you have indicated or any conditions not listed here….

_____

_____

_____

Medications (Over-the-Counter and Prescription)				
Name	Dosage	Frequency	Length of Time	Reason for Taking

Vitamins, Minerals or Herbal Supplements					
Name	Brand	Dosage	Frequency	Length of Time	Reason for Taking

Have you had any surgery?

_____

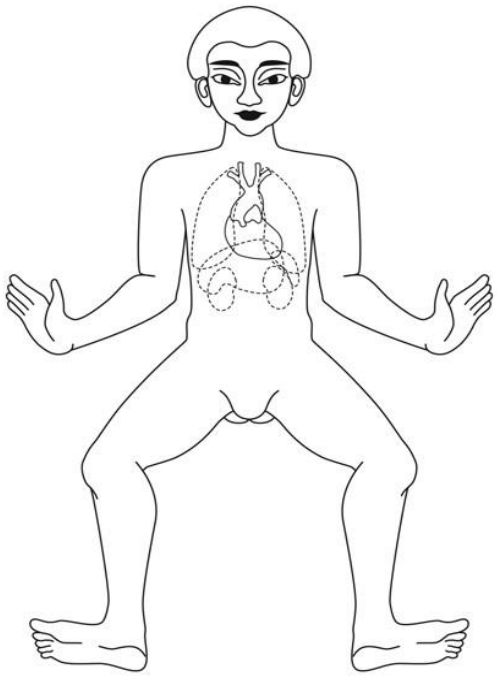
Do you experience any acute or chronic illness/es?

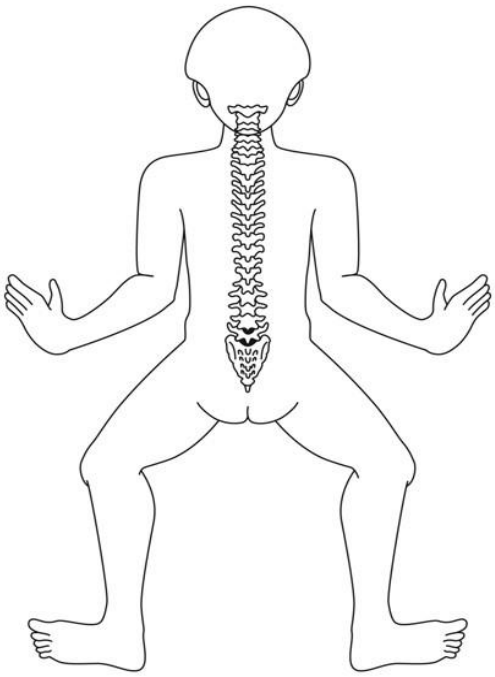
_____

Have you ever been diagnosed with a mental health condition?

Depression / Anxiety / PTSD / Other

Circle any problem areas and indicate: Tension “T”, Pain “P”, Surgeries, “S”.





Do you have any restrictions in movement? _____

Are you currently exercising regularly? _____

Are there any movements or stretches that you have been advised to avoid? _____

_____

Please advise the healthcare practitioners you are currently working with

_____

_____

Does your Doctor or healthcare practitioner/s know that you are participating in Yoga Therapy?

Collaboration among healthcare practitioners may lead to a more thorough approach to your care. With your permission (information disclosure form), Meagan may, if needed, contact other members of your healthcare team.

Do you eat regular meals?

What is your average daily caffeine intake?

Do you use tobacco products?

What is your average water intake?

Do you have any food sensitivities or intolerances?

Describe your energy levels… *Please circle any you have experienced*

High	Low	Vibrant
Agitated	Fatigue	Clear
Chaotic	Dull	Even

Does this energy fluctuate or remain constant?

When is your energy at its highest?

When is your energy at its lowest?

Describe your energy upon awakening?

On average, how long do you sleep? *Please circle*

Less than 3hrs / 3-4hrs / 4-6hrs / 7-8hrs / 8-10hrs / 10+hrs

Do you experience insomnia or struggle to stay asleep?

What are your primary reasons for coming to yoga therapy? *This is an opportunity to define your health and well-being goals*

Do you have any other comments or requests? _____

Client Consent and Agreement - Please read and sign below

1. It is agreed and understood that Yoga Therapy is a complementary health practice and is not meant to diagnose any illness, disease, injury, physical condition, or mental disorder.

2. Meagan Walker is a fully accredited and registered yoga therapist with Yoga Australia. A yoga therapist is not a medical doctor. Yoga therapy does not replace the need for a medical advice and should not be used to defer seeking advice from a trained medical professional.

3. Except in cases of emergency, I agree to pay for all sessions which are not cancelled at least 24 hours in advance.

4. In consideration of being permitted to participate in Yoga Therapy I agree to assume full responsibility for any risks, injuries or damages, known or unknown, which I might incur as a result of participating in the program.

5. In further consideration of being permitted to participate in Yoga Therapy, I knowingly, voluntarily and expressly waive any claim I may have against Meagan Walker and Meagan Walker Yoga Therapy for injury or damages that I may sustain as a result of participating.

I have read the above release and waiver of liability and fully understand its contents. I voluntarily agree to the terms and conditions stated above.

SIGNATURE OF PARTICIPANT

_____ DATE _____

SIGNATURE OF PARENT/GUARDIAN if participant under 18 years of age

_____ DATE _____

mylittleyogastudio@outlook.com

0408 150 431