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New Client Intake

Date:	
Name:	
Address	
City, State, Zip	
Phone #:	
Email Address:	
Occupation:	
Emergency Contact Name/Phone:	

1. Have you practiced yoga before? Yes No
2. How often do you practice yoga? (Circle one) Never Once every few weeks Once a week A few times a week Daily
3. What styles of yoga have you practiced before? (Check all that apply)

- ☐ Ashtanga
- ☐ Hot
- ☐ Bikram
- ☐ Kundalini
- ☐ Yin
- ☐ Restorative
- ☐ Power Yoga
- ☐ Hatha
- ☐ Iyengar
- ☐ Vinyasa
- ☐ Not sure

5. On a scale of 1-10 (10 being the highest), how would you rate your level of daily activity? _____
6. On a scale of 1-10 (10 being the highest), how would you rate your level of daily stress? _____
7. What are your health goals for your yoga practice? (Check all that apply)

- ☐ Weight loss/weight maintenance
- ☐ Strength building
- ☐ Flexibility
- ☐ Improved mobility
- ☐ Stress relief
- ☐ Alternative therapy (please explain below)
- ☐ Address specific health concern (please explain below)
- ☐ Emotional balance/Inner peace

(Continued on reverse side)

☐ Other/Explain more: _____

_____

8. Which aspects of yoga are you most interested in? (Check all that apply)
   - ☐ Physical postures
   - ☐ Yoga philosophy
   - ☐ Breathwork/Pranayama
   - ☐ Meditation

9. Please check any of the following health conditions that apply to you:

☐ Anemia	☐ Degenerative Disc	☐ Osteoporosis
☐ Anxiety	☐ Depression	☐ Scoliosis
☐ Arthritis	☐ Diabetes	☐ Pregnancy
☐ Asthma, shortness of breath	☐ Heart conditions, chest pain	Est. due date) _____
☐ Back pain/injury	☐ High Blood Pressure	☐ Sciatic
☐ Bulging Disc	☐ Knee Pain/Injury	☐ Seizures
☐ Cancer (explain below)	☐ Joint Replacement (explain below)	☐ Stroke
☐ Muscle pain	☐ Low Blood Pressure	☐ Surgery (explain below)
☐ Muscle Weakness		☐ Other (explain below)

☐ Other/Explain more: _____

_____

_____

I authorize the collection and use of the above personal information as is required for therapeutic treatment and related administrative purpose. I understand that all my personal information is confidential and will not be released without my signed consent.

I understand that yoga is not a substitute for medical attention, examination, diagnosis or treatment. Yoga is not recommended and is not safe under certain medical conditions. By signing, I affirm that a licensed physician has verified my good health and physical condition to participate in yoga classes offered by {insert company name here}. In addition, I will make my yoga instructor aware of any medical conditions or physical limitations before class. If I am pregnant, become pregnant or I am post-natal or post-surgical, my signature verifies that I have my physician's approval to participate. I also affirm that I alone am responsible to decide whether to practice yoga and participation is at my own risk. I hereby agree to irrevocably release and waive any claims that I have now or may have hereafter against {insert company name here}.

Name: _____

Signature:_____ Date: _____

☐ **Check here if you do NOT want your image to be used in any promotional materials or communications regarding Mountain Yoga.**