otyoga

Health History and Intake Form

Name _____

Birth Date_____ Gender identity and preferred pronouns _____

Address _____

Phone _____ Alternate phone _____ Email _____

Emergency contact name/phone/relationship _____

Occupation _____

Educational Background _____

Primary health care provider _____ Phone _____

Have you consulted your health care provider about starting yoga therapy? _____

How did you hear about Patricia Barnes Therapeutic Yoga? _____

Reproductive status:

For women:

Are you pregnant? _____ Which trimester? _____

Do you have children? _____ Ages _____

Post-partum depression? _____ Women's health issues? _____

Are you pre/ peri or postmenopausal? _____

For men:

Do you have any prostate issues? _____

List medications/ supplements and herbs you take, and what they are for.

_____

_____

Allergies? _____

Have you had any major illnesses or injuries? Please explain. _____

_____

_____

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Do you have, or have you had, any of the following conditions:

- ○ Heart problems
- ○ High blood pressure?
- ○ Low blood pressure?
- ○ Arthritis
- ○ Chronic illness (explain below)
- ○ Lung problems
- ○ Surgery ___/___/___ Date (explain below)

  _____

  _____
- ○ Neck, back or joint problems (explain below)

  _____

  _____
- ○ Diabetes
- ○ Heel spurs, tennis elbow, carpal tunnel or overuse syndrome?
- ○ Headache/ Migraines
- ○ Cancer
- ○ Seizures or loss of consciousness
- ○ Accidents i.e. car, falls, physical trauma
- ○ Depression
- ○ Anxiety
- ○ ADD/ ADHD
- ○ Autism or related disorder
- ○ Osteoporosis
- ○ Scoliosis
- ○ Thyroid condition
- ○ G/I Issues
- ○ Eye problems
- ○ Ear problems
- ○ Nose or throat problems
- ○ Fibroids/ tumors
- ○ Varicose veins
- ○ Excessive fatigue/ ME
- ○ Hernia
- ○ Sleep issues

Do you have any specific sensitivities, physical or psychological, that you want me to know about so I can support you better?

_____

_____

_____

How would you describe your diet? Ex. salt, sugar

_____

_____

_____

Do you engage in recreational or habitual use of substances, i.e. drugs, caffeine, tobacco or alcohol?

_____

_____

_____

Have you been in counseling or psychotherapy or under psychiatric care? What was your experience with that treatment?

_____

_____

_____

What diseases, if any, run in your family?

_____

_____

_____

What time of day do you feel most energetic? _____

On a scale of 1-5 how would you rate your stress currently ___ and over the past 6 months ___ (1 is low and 5 is high) Ex. Work, family, relationships, health

On that same scale how would you rate any pain currently ___ and over the past 6 months, if applicable ___

Do you currently employ any stress management techniques such as physical exercise, yoga and/or other movement systems, bodywork, breathwork, meditation, journaling, etc.? If so, which ones?

_____

_____

_____

How effective are they for you?

_____

_____

_____

Why are you here today and what do you hope to gain from this experience? What aspects of yoga therapy appeal to you most at present? Ex. Strength, fitness, emotional and/or spiritual well-being?

_____

_____

_____

Purpose, Policy, and Privacy
Your yoga therapist intends to provide a safe and enjoyable yoga therapy experience for you, the client. In the case of virtual yoga therapy, the client takes responsibility for maintaining a safe space for participating in yoga therapy sessions/ classes. Yoga therapy is not a substitute for any other medical/ healthcare.

While your records will be maintained in a confidential manner, your yoga therapist is not following full HIPPA measures. Your yoga therapist respects your privacy and confidentiality. She will not discuss your situation with any third parties. There is one exception: if your yoga therapist determines that you may be a risk for harm to yourself or others, she may find it necessary to contact the appropriate services. In this case, she will discuss the situation with you prior to making any additional contacts. Every effort will be made to protect your identity.

Payment is due on or before the date of services. If you need to cancel or re-schedule, please provide 24-hour notice. If you cancel within 24 hours, or are a “no-show” for an appointment, you forfeit the amount of that visit.

By signing below, I confirm that I understand and consent to the terms explained above.

_____
Print name

_____
Signature

_____
Date