



**NEW/RETURNING PATIENT INFORMATION**

DATE \_\_\_\_\_  
 LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_  
 DATE OF BIRTH \_\_\_\_\_ GENDER: F \_\_\_ M \_\_\_

HAVE YOU EVER RECEIVED YOGA? YES \_\_\_ DATE \_\_\_\_\_ NO \_\_\_  
 PRIMARY REASON FOR INTEREST IN CLASS? \_\_\_\_\_  
 HOW DID YOU HEAR ABOUT OUR PROGRAM? \_\_\_\_\_  
 DO YOU HAVE ANY AREAS OF PAIN, TENSION OR PROBLEMS? \_\_\_\_\_

WHAT IS YOUR OCCUPATION? \_\_\_\_\_  
 DO YOU EXERCISE REGULARLY? YES \_\_\_\_\_ NO \_\_\_\_\_ TYPE OF EXERCISE \_\_\_\_\_

ARE YOU UNDER A DOCTOR, CHIROPRACTOR OR OTHER HEALTH PRACTITIONER'S CARE?  
 YES \_\_\_\_\_ NO \_\_\_\_\_  
 IF YES, PLEASE DESCRIBE \_\_\_\_\_  
 PHYSICIAN'S NAME \_\_\_\_\_  
 ARE YOU TAKING ANY MEDICATIONS YES \_\_\_\_\_ NO \_\_\_\_\_  
 IF YES, PLEASE LIST \_\_\_\_\_

HAVE YOU BEEN IN AN ACCIDENT OR SUFFERED INJURIES IN THE PAST TWO YEARS?  
 YES \_\_\_\_\_ NO \_\_\_\_\_  
 ARE YOU PREGNANT OR NURSING? YES \_\_\_\_\_ NO \_\_\_\_\_

**PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING:**

FOOD ALLERGIES	_____	PLEASE LIST: _____
ALLERGIES	_____	ARTHRITIS _____
BLOOD CLOTS	_____	CARPAL TUNNEL _____
DIABETES	_____	HEART DISEASE _____
JOINT PROBLEMS	_____	LOW BLOOD PRESSURE _____
RESPIRATORY PROBLEMS	_____	SKELETAL INJURIES _____
SPINAL PROBLEMS	_____	VARICOSE VEINS _____
CHEST PAIN	_____	CONSTIPATION _____
DIZZINESS	_____	DEPRESSION _____
INSOMNIA	_____	MIGRAINE HEADACHES _____
JAW PAIN/TMJ	_____	WARTS _____
EPILEPSY OR SEIZURES	_____	NUMBNESS _____
OSTEOPOROSIS	_____	ATHLETES FOOT _____
CIRCULATORY PROBLEMS	_____	HIGH BLOOD PRESSURE _____
MUSCULAR INJURIES	_____	SKIN PROBLEMS _____
ABDOMINAL PAINS	_____	DIGESTIVE PROBLEMS _____
FATIGUE	_____	SINUSITIS _____
BRUISE EASILY	_____	STABBING PAIN _____

PLEASE DESCRIBE ANY CONDITION YOU CHECKED ABOVE OR THAT WOULD PRECLUDE YOU FROM PERFORMING THE EXERCISES: \_\_\_\_\_



**NEW/RETURNING PATIENT INFORMATION (cont.)**

IN CASE OF AN EMERGENCY, PLEASE NOTIFY:

NAME: \_\_\_\_\_ PHONE # \_\_\_\_\_

I understand that the Yoga Instructor does not diagnose illness, disease, or any physical disorder. The Yoga instructor does not prescribe treatment or medications or perform spinal manipulation. Yoga is not a substitute for medical examination or diagnosis.

I have, to the best of my knowledge, stated all of my known medical conditions. I take it upon myself to keep the instructor updated on my physical health. I understand that any illicit or sexually suggestive remarks/advances made by me will result in immediate termination of the session. I will be liable for payment of the scheduled appointment.

CLIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PRACTITIONER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

\* Consent to treatment of Minor, by my signature, I hereby authorize the instructor to administer Yoga Instructor to my child or dependent as they deem necessary.

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_