Yoga Therapy
New Client Questionnaire

INSTRUCTIONS FOR YOUR FIRST YOGA THERAPY CONSULTATION

Thank you for giving thoughtful consideration as you complete this New Client Questionnaire. You will have ample opportunity to address any concerns that require more detail during your appointment with your practitioner.

Required for your first visit:
- The completed New Client Questionnaire

Please also bring the following:
- Comfortable clothing

Client confidentiality will be observed under all circumstances.

If you do have any questions please contact your practitioner:

_____

YOGA THERAPY
New Client Questionnaire

Client confidentiality will be maintained at all times. The information provided on this questionnaire may only be disclosed with the express written consent of the individual named herein or, if under the age of 18, his or her legal guardian.

Please allow 25-30 minutes to complete this questionnaire. Please answer the questions below as thoroughly as possible so that we may make the best possible clinical assessment and develop a realistic and workable plan for supporting you in reaching your health goals. Your answers to personal questions such as relationship status, religion, etc. are important as they provide helpful context for establishing a productive partnership with you. That said, please answer only the questions you are comfortable answering.

Today's Date:

Contact Information			
Name:		Address:	
Work phone:		Home phone:	
Mobile phone:		Email:	
Preferred contact method:		Best time(s) of day to reach you:	
Demographic Information			
Gender:		Date of Birth:	Age:
Height:		Weight: (lbs.)	Ethnicity:
Emergency Contact			
Name:		Relationship:	Phone:
Occupation & Interests			
Occupation:		How long?	Satisfied?
Relationship Information			
Status:		Partner's Name:	
Personal Information			
Education:			
With whom (persons or animals) do you share your home?			

Please tell us about the healthcare practitioners with whom you are currently working?

Health Practitioner Contact Information			
Name:		Name:	
Specialty:		Specialty:	
Office phone:		Office phone:	
Fax:		Fax:	
Address:		Address:	

Does your doctor/healthcare practitioner know that you are participating in Yoga Therapy? **Y N**

Collaboration among healthcare providers can lead to a more thorough approach to your care. May we have your permission, if needed, to contact other members of your healthcare team? **Y N**

(If you answered yes to the above question, kindly complete an information disclosure form.)

What are your primary reasons for coming to the Yoga Therapy?

1.
2.
3.

Is there anything that surfaced during a recent medical test, lab work, or doctor's visit that you would like to report?

Please place an "X" next to anything you are currently experiencing. Issues that you had previously, but no longer have, mark with a "P".

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
Respiratory	Swollen or Painful Lymph Nodes	Diarrhea	(Which Trimester? ___)
Lung Issues	Poor Circulation	Constipation	Peri/Post-Menopausal (Please Circle)
Allergies			Men: Prostate Issues

Any surgery, acute, or chronic illness? (Please list)			
Year	Description	Ongoing Yes/No	Additional Information

How would you describe your overall health?

Is there now or has there historically been any illness or physical challenges which may impact your Yoga practice? Please share below:

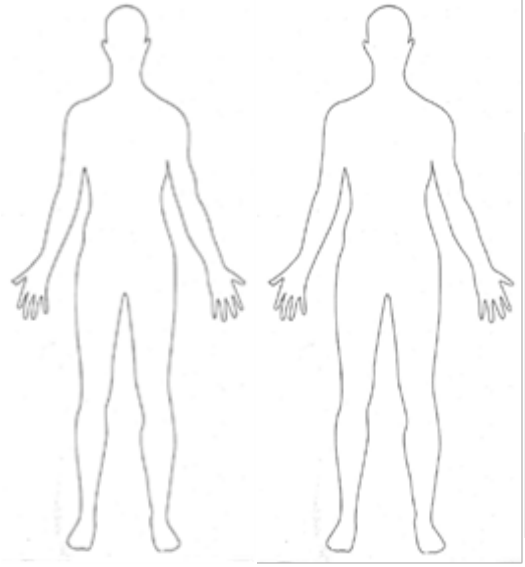
Medications (Over-the-Counter and Prescription)				
Name	Dosage	Frequency	Length of Time	Reason for Taking

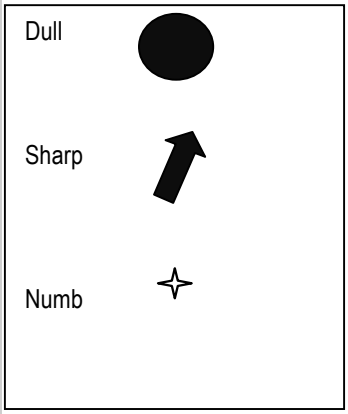
Vitamins, Minerals or Herbal Supplements					
Name	Brand	Dosage	Frequency	Length of Time	Reason for Taking

Dietary Intake					
Do you eat regular meals?		How much caffeine do you consume in a day?		Do you use tobacco products?	
How much water do you drink in a day? (Oz.)		Any food sensitivities or intolerances?			

Musculoskeletal System & Pain

On the following diagram, if you are experiencing any pain, please show the location of your pain/discomfort/stiffness and use the following symbols to describe it:





FRONT BACK

Does anything make your pain/discomfort better?	
Does anything make your pain/discomfort worse?	
Is there a daily pattern to your symptoms?	

Do you experience any of the following in your body?: (Please circle all that apply & write the location of the sensation)

Stiffness	Weakness	Discomfort	Tightness
Decreased Mobility	Excess Mobility	Fatigue or Decreased Endurance	Limitations in Daily Activities

Energy Level

Do you ever experience your energy level as any of the following?: (Please circle all that apply)

High	Agitated	Chaotic		
Low	Fatigue	Dull		
Vibrant	Clear	Even		

Does your energy fluctuate or is it constant?	
When is your energy at its highest?	
When is your energy at its lowest?	
What is your energy like when you first awaken?	
On average, how long do you sleep at night?	
Do you struggle with insomnia or staying asleep?	

Emotions/Moods

Are you having difficulty with any of the following?:

☐ Anxiety	☐ Fear	☐ Sadness	Explain if desired:
☐ Depression	☐ Grief	☐ Despair	
☐ Negative Self-Talk	☐ Anger	☐ Other Emotions	

Have you ever been diagnosed with a mental health condition? **Y N (If yes, please circle any that apply)**			
Anxiety	Depression	PTSD	Other:
How would you describe your overall mood and energy level?			

Stress Response & Coping Strategies							
On a scale of 1-10, with 1 being low and 10 being high, how stressful is your:							
Work:		Social/family situation:		Current health status:		Life in general:	
What strategies do you use to manage stressful and emotional situations?							
Do you have people in your life in which you can confide or go to for counsel?							
Is there anything about your family relationships that you would like to share?							
Which aspects of your life give you the most joy and pleasure?							
Briefly describe your passions and interests?							
How do you express yourself creatively?							
Please describe your Spiritual Practices and Beliefs.							

Significant Life Events	
Please list major events in the last ten years of your life and the dates they occurred. Include births, deaths, marriage, divorce, accidents, moves, jobs changes, miscarriages, illness, and anything else you feel greatly impacted your life.	
Date	Event

Physical Activity & Yoga Experience	
Describe your level of physical activity with regard to the following:	
Aerobic/Fitness Exercise	
Working with Weights	
Other	
What is your previous experience with yoga, meditation, complementary, alternative health and healing?	
Do you currently practice yoga? **Y N (If yes, please answer the following)**	
How often & which style?	
Do you practice at a studio?	
Do you have a home practice?	
What do you find is the most challenging?	
Is there anything else you would like to ask me?	

Thank you for taking the time to complete this questionnaire.