YOGA THERAPY INTAKE **Please Print or Use Text**

Therapist: *Julianne Hutchcraft, RN, BSN, C-IAYT, E-RYT, AYS, Thai Yoga Therapist*

Today's Date_____

Client Name_____
Age_____Birthdate_____
Marital Status_____
Address_____
_____
Phone_____
Email_____

Occupation_____
_____
Spiritual/Religious Affiliation_____
Referred by_____
Emergency Contact_____
Emergency Phone_____

Height_____ Weight_____

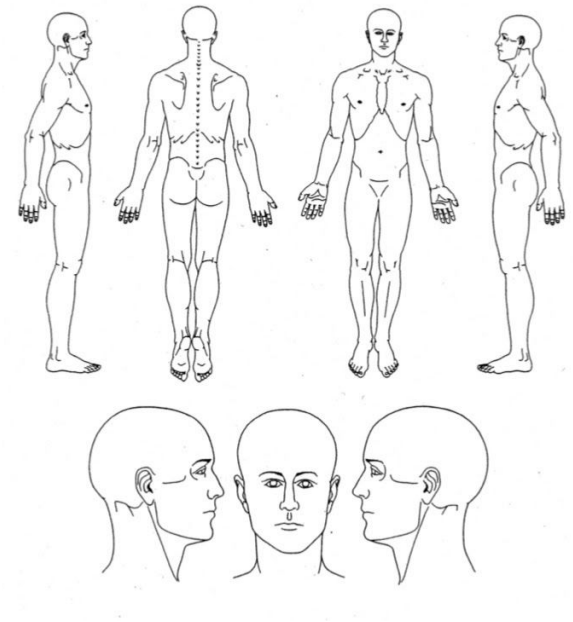
MAIN COMPLAINT (Include any pain or tension. For how long?):

Current Medical Issues and Treatments:

Past Medical Issues and Treatments:

Therapist Signature:

PAIN RECORD
With a red pencil, color the areas where you have been experiencing pain recently. Dark red indicates more pain, less red indicates less pain.



Current Pain Level 0-10/10 (0-none, 5-moderate, 10-severe) :_____

Is it worse in the morning or evening?

Does your work or any other activity increase your pain/tension?

What helps relieve your pain/tension?

Are you currently on pain medication? YES/NO

- If yes, what do you take, how much and how often? _____

YOGA THERAPY INTAKE **Please Print or Use Text**

Are you currently under the care of a physician, mental health therapist and/or an alternative medicine practitioner? YES/NO

1. If yes, what are you being treated for?
   _____
   _____
   _____
2. Name(s) & Phone(s):
   _____
   _____
3. Did you receive your Doctor's or Therapist's permission to work with a Yoga Therapist? YES/NO/NA

Are you currently under the care of a chiropractor? YES/NO

1. If yes, what are you being treated for?
   _____
   _____
2. Name & Phone:
   _____
   _____

Are you currently receiving any other body or energy therapies? YES/NO

- If yes, what for?
  _____
  _____

Please list any medications, vitamins, supplements and herbs you are currently taking:

Please CIRCLE any of the following that apply to you (in the past or currently):

Heart problems High blood pressure
Blood clots Varicose Veins
Pacemaker Neurological problems
Headaches Arthritis
Osteoarthritis Wears Contact Lenses
Pregnant Diabetes
Surgery Epilepsy or Seizures
Back problems Spinal problems
Disc problems Joint problems
Accidents, injuries, sprains or fractures
Major illness or disease

What is your physical activity or exercise routine? (Include frequency and for how long. Include sports, yoga, walking, gardening, etc.)

What is YOUR GOAL for Yoga Therapy?

CONSENT FOR YOGA THERAPY

I understand that the purpose of yoga therapy is to support my physical, mental and emotional well-being in a therapeutic setting using yogic tools, such as postures/exercises, breathwork, relaxation and meditation techniques. It is not meant to diagnose or treat any illness, disease or any other physical or mental disorder, injury or condition. I have informed my yoga therapist about my state of health and any recommendations and restrictions on the part of my medical doctor or mental health therapist insofar as yoga therapy is concerned.

Client signature: _____

Date: _____

Therapist Signature: