Ayurveda, although somewhat recently introduced to the United States, has been practiced in India for over 5000 years. The medical establishment of this country however, does not presently recognize Ayurveda. _________________________, is available to teach you these health-promoting principles and encourage you to coordinate them with your conventional health care. Ayurveda is a very sacred art and science, and deserves respect and care to maintain its purity.

Please consult regularly with your medical doctor, if necessary, and do all things recommended to insure your continued good health. Thank you for trusting me to work with you on your health.

I would like to receive a consultation by _________________________ regarding health education, diet, herbs, cleansing and rejuvenation. I understand that this is an educational session to help me understand my body’s natural healing abilities. As such, I take full responsibilities for the choices in health that I make, including the use of any medications prescribed by my primary care physician. I understand that the use of natural methods may cause a cleansing or detoxification effect from medications and/or poor health choices. I am aware that these services are generally not covered by insurance and that all fees will be paid at the time services are rendered by cash or check. I understand that my first consultation is _________________________ I hereby waive any present or future claims of liability against _________________________ that may arise out of any treatment sought and received by her.

I have read and understood the above.

________________________________________________ ______________
signature date
Yoga Therapy Intake Form

Name:_________________________________________________________________

email:_________________________________________________________________

Phone: ________________________________________________________________

Age:______________________Height________________Weight________________

What are your current reasons for seeing a yoga therapist? Do you have a goal for our
time together?
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

List your current & previous health conditions? Please include medical diagnoses,
surgeries, accidents, injuries, etc., and approximate dates.
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

How long has your current health issue been going on?______________________

Who else are you currently seeing for your health concerns or general health promotion?
How often do you see them?
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Please state the areas of discomfort in your body. Try to describe where they are located
and type/degree of discomfort.
_______________________________________________________________________
_______________________________________________________________________
Where do you hold tension in your body?

What relieves your pain? What increases it? (Consider the movements and range of motion that affect you).

Please describe your overall energy level. Does it fluctuate or stay consistent? When are you most energized, least energized?

How do you perceive the stress levels in your current life – low, moderate, high?

Check any of these emotions that you feel on a regular basis. Are there places in your body where these feelings tend to dwell when they come up? Please list.

Psychology
___Worry  ___Anxiety / Fear  ___Overwhelm  ___Spaced Out  ___Insomnia  ___Self-destructive  ___Indecisive
___Irritable  ___Anger / Rage  ___Aggressive  ___Jealousy / Envy  ___Critical / Judgmental  ___Intense / Sharp
___Lethargy  ___Sadness  ___Depression  ___Greediness  ___Over attachment  ___Procrastination  ___Controlling
Other: ______________________________________________________________________
What life challenges are your currently facing?
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

What aspects of your life gives you the most joy and pleasure?
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

If you could change one thing, what would it be?
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Daily routine and Habits:

In percentages, how much of your day is spent with the following:
- Sitting__________    Driving__________
- Standing__________    Desk work_________
- Lying__________    Lifting__________

Hours of sleep nightly____ Time you go to sleep____ Time awaken____
Are you usually refreshed on awakening___Yes ___No
Type of sleep: ___Light ___Medium ___Heavy
Ease in falling asleep: ___Variable ___Easy ___Medium ___Difficult
Ease in waking up: ___Easy ___Medium ___With Difficulty

What are your favorite physical movements? Least favorite? Do you have a regular
exercise program? Please describe?
_______________________________________________________________________
How much time (each day/week/month) can you devote to your own personal yoga practice?


Please check off items below that apply to you on a chronic or recurrent basis at the present time or within the past year:

I. Digestion

___Heaviness after eating
___Bloating after eating
___Sleepy/low energy after eating
___Belching
___Nausea

Hunger Level: ___Variable ___Strong ___Average ___Low

II. Elimination

___Constipation (<1 BM / day) ___Diarrhea
___Alternate between diarrhea & constipation ___Difficult/painful bowel movements
___Hemorrhoids

Stool consistency: ___loose ___soft ___hard ___pellets ___dry
Stool density: ___float ___sink ___scatter
Stool color: ___clay color ___brown ___other ___________

Number of bowel movements per day_______

Diet: What types of foods are eaten on a regular basis? (at least twice/week)

Breakfast:_____________________________________________________________
Lunch:_________________________________________________________________
Dinner:_________________________________________________________________
Snacks:_________________________________________________________________

How much water do you drink per day? _________________________cups / ounces

How many cups of caffeinated beverages per day?_______Type(s) coffee / tea / soda

How many glasses of alcohol per day?______________Type(s) beer / wine / hard liquor

How many cups of non-caffeinated beverages do you drink per day? _______
Type(s) of beverage: milk / juice / herbal tea / other _______________
Please list your current medications vitamins, herbs and supplements.

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