LifeForce Yoga Intake Form

Name:

Address:

Phone: (home) _____(cell)_____(work)_____

Email Address:

Date of birth:

Place of birth:

Occupation:

Please describe your current overall health:

Please describe your current mental health:

Please describe your current yoga and/or meditation practice, if applicable:

How long have you been practicing?

Are you currently taking medication? If so, please list name, dosage and reasons for each prescription:

Are you currently working with a Psychiatrist? If so, please provide name and phone #.

Are you working with other Mental Health Professionals?

Are you working with any complementary medicine providers?

Do you currently have any medical conditions you are being treated for? Please list all conditions that could affect your yoga practice (i.e. bone, muscle, ligament, tendon problems; heart, lung, high blood pressure, epilepsy, diabetes, thyroid, retinal conditions, pregnancy).

Please describe any problems with your digestion:

Please describe and current or past history with eating disorders or disordered eating. Include types of treatment, if applicable.

Do you have any respiratory issues?

Please describe any problems associated with menstruation, perimenopause, or menopause:

Please describe any sleep disturbance you may have.

Marital Status/Name & contact # for partner, if applicable:

With whom do you live?

Names/ages of children:

Please list any pregnancy losses:

Pets:

Hobbies & Interests:

What brings you joy?

What causes you stress?

Please describe your work environment:

Religious background: Current religious affiliation:

Do you have a spiritual practice? Please describe:

How do you feel about your significant relationships?

How do you feel your upbringing has influenced your current situation?

What qualities would you like to experience in your life...are there things you feel are missing at this time?

What else would you like me to know about you?