Therapeutic Yoga Client Waiver

Name: _____ Phone: _____

Email: _____ Birthday: _____

Address: _____ City: _____

Zip: _____ Profession: _____

Gender Identification: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

I understand that Yoga includes physical movements as well as an opportunity for gained awareness, and relief of muscular tension. I recognize that this may require some physical exertion, which may cause physical injury, and I am fully aware of the risks and hazards involved.

If I experience any pain or discomfort, I will listen to my body, stop the movement, and ask for support from Leta.

Yoga is not a substitute for medical attention, examination, diagnosis, or treatment. These forms of exercise are not recommended and are not safe under certain medical conditions. I understand that it is my responsibility to consult with a physician prior to and regarding my participation in any sessions with Leta. I represent and warrant that I am physically fit and I have no medical condition which would prevent my participation.

I knowingly, voluntarily and expressly waive any claim I may have against Leta Willcox, Yoga with Leta, The Doc & The Yogi LLC, Sand Springs Chiropractic LLC, or Sand Springs Chiropractic & Wellness for any injury or damages that I may sustain as a result of participating in the program as stated above.

I have read the above release and waiver of liability and fully understand its content. I voluntarily agree to the terms and conditions stated above.

Signature: _____ Date: _____

Yoga Therapy Intake

Concerns

What brings you here today?

Please describe any current physical issues (in addition to any listed above) that you are dealing with today. Include what and how long and if you are being treated by a healthcare practitioner for that issue.

Medical Information

Please list surgical history and dates.

Please list medications (Rx/OTC) Include name, purpose and how long you have taken them:

Supplements / Herbs:

Do you have any allergies? (food allergies, medication allergies, seasonal, scent related, etc) Please list below.

_____

_____

Physical Activity

How would you describe your activity level daily (circle one):

Sedentary *Moderately Active* *Very Active*

Are you satisfied with your current level of activity? _____

How many hours a day do you sit?

Weekday: _____ *Weekend:* _____

What activities do you enjoy doing in your leisure time? List approximately how many days a week you participate in these and for how long?

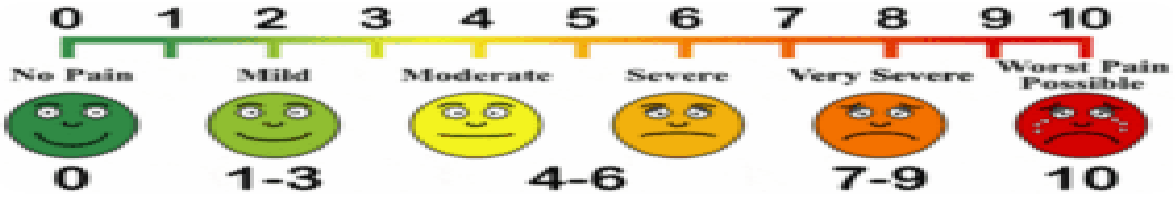
_____

_____

_____

Current Pain or Discomfort

Are you currently working through body discomfort? If so, please list the areas of discomfort along with an average discomfort rating. Please use the following guideline in rating your discomfort level and feel free to add any additional information you want to share.



Area of discomfort *Average discomfort rating* *Rating at worst* *Rating at best*

_____

_____

Area of discomfort	*Average discomfort rating*	*Rating at worst*	*Rating at best*

How have the above concerns limited activities of daily living or any activities you enjoy?

Of the areas listed above, which is your greatest concern at this time? Why are you most concerned about this area?

Are there any activities/strategies that help decrease discomfort in any of the areas listed? Please describe the strategies utilized to help manage discomfort levels.

Have you been treated for any of the areas listed in the previous section by a rehabilitation professional (i.e., acupuncturist, chiropractor, massage therapist, physical therapist, etc.)? If so, please describe your experience with the intervention(s) (i.e., treatments utilized, effectiveness of treatment with discomfort level, functional changes, etc.).

Dietary Information

How would you describe your typical daily food intake/nutritional status?

_____

_____

_____

_____

Current daily fluid intake

Please estimate how many ounces of water you drink daily: _____

Caffeinated beverages: _____ Type: _____

Energy drinks/soda: _____ Other: _____

Other Information

Please describe your current sleep status. (ie hours/night, sleep quality, sleep issues, etc)

_____

_____

_____

Please mention any significant feelings, emotions, stresses, issues or relationships in your life that you are struggling with:

_____

_____

Are you currently involved in any support groups, spiritual groups, or other social outlets they you feel are crucial to your well- being? Please feel free to share specifics regarding your current social outlets.

_____

_____

What are your goals for the therapeutic yoga process?

In the course of a typical week, how much time are you able to commit to the process of achieving these goals? Do you perceive any barriers in committing this time?

Please share anything else you would like your yoga therapist to know.

Signature: _____ Date: _____

General Information & Policies

Helping Things Run Smoothly

General Information

- Wear comfortable, non-restrictive clothing that you can move well in.
- A restroom is available that may be used as a changing space.
- Please silence your cell phone during our time.
- Your time is scheduled just for you! Because of this I cannot go past your scheduled time if you are late for a session.

Privacy Policy

- Your privacy is very important to us. Any personal information you choose to give us will only be used to help us provide you with the highest quality services, and support.
- We will never share your personal information with any other party without your consent.

Cancellation Policy

- I have a 12-hour cancellation policy for all sessions. If you miss a session or cancel within 12-hours of your scheduled time you will be charged for the session at the beginning of your next class. I reserve the right to waive this fee under mitigating circumstances, i.e. sudden illness, etc.

Thank you for your understanding in this.

I have read the above policies and fully understand its content. I voluntarily agree to the terms and conditions stated above.

Signature: _____ Date: _____

Please bring with you to your appointment

Name: _____

Please let me know your areas of tension, tightness or pain. Feel free to use the extra space to write your comments.