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# YOGA THERAPY INTAKE

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|---|---|
| Name: | |
| Birthdate: | Age: |
| Phone number(s): | |
| Email: | |
| Emergency Contact name/number: | |
| Home Address: | |
| Referred by: | |
| Current Spiritual or Religious practice if any: | |
| Accessibility needs, if any: | |
| Occupation: | |
| Please list other services you are receiving (i.e. mental health therapy, physical therapy, MD, ND, acupuncture, etc.): | |
| What are your current reasons for seeing a yoga therapist? Do you have a goal in mind? | |
| Please briefly describe what you are currently experiencing, including onset/diagnosis (if applicable): | |

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| Describe any areas of discomfort and/or pain in your body. Try to describe where they are located and type/degree of discomfort. Rate your level of pain, using a scale of 1 to 10, with 10 being the highest level of pain. |
| What relieves your pain? What increases your pain? |
| What functional movements and tasks are difficult for you? Reaching, bending, twisting, etc? |
| What are your favorite physical movements? How about least favorite? Please describe your regular exercise program if you have one. |
| Are you aware of any imbalances or tension in your body? Are satisfied with your posture? |
| What do you think is getting in the way of making the changes you want in your life? |
| Diet: How much water do you drink per day? |
| How many cups of caffeinated beverages per day? |
| How many cups of non-caffeinated beverages do you drink per day? |

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| Please list your current medications, vitamins, herbs and supplements (including dosage, how long you have taken them, and reason) |
| Do you or have you ever smoked? |
| Briefly state your daily routine, in percentages of how much of your day is spent in the following:<br>- Sitting:<br>- Driving:<br>- Standing:<br>- Desk work:<br>- Lifting:<br>- Lying:<br>- Walking: |
| Does your daily routine consistent or variable from day to day? |
| Please describe your overall energy level. Does it fluctuate or stay consistent? When are you most energized? When are you least energized? |
| Do you have difficulty breathing? Do you notice changes in your breath when you become upset or agitated? |
| Describe your sleep habits? |
| When do you normally turn off all digital media? |
| What are your perceived stress levels? |

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| What challenges are you currently facing? Do you keep running up against the same problems/situations in life? |
| Do you have a spiritual practice? |
| Describe a natural scene that you can easily visualize which is healthy, inspiring, joyful, and grounding. What sounds, fragrances, colors, feelings inspire you in this scene? |

Please check off 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?

__ Worry
__ Irritable
__ Anxiety/fear
__ Lethargy
__ Overwhelm
__ Jealousy/Envy
__ Spaced out
__ Anger/rage
__ Aggressive
__ Depression
__ Sadness
__ Greediness
__ Insomnia
__ Critical/Judgmental
__ Over attachment
__ Self-destructive
__ Intense/sharp
__ Procrastination
__ Indecisive
__ Tension
__ Controlling

# Fee Scale and Agreement

**The following is a fee agreement. Please read carefully before signing and ask for clarification on any portion that you do not understand. Please initial after each statement indicating that you understand and agree to the statement:**

1. I agree to pay all fees at the beginning of our session. The fee per session is $75.00 or $125 to travel on-site.

   Initials: _____

2. **Cancellation policy**: There will be no charge if appointments are cancelled 24 hours in advance. Cancellations with 24 hours of the scheduled time will be charged the full fee.

   Initials: _____

3. Wholistic Hearing Care does not bill insurance companies in any circumstances for any yoga therapy related treatment. The only document provided is a receipt with specific codes if applicable, and receipts are emailed once/month. Clients have been successful in receiving reimbursement from their insurance companies in the past.

   Initials: _____

4. **Returns/Refunds:** Pre-paid packages are non-refundable nor non-transferable. They expire one year from date of purchase.

   Initials: _____

**I have read the above agreement and understand its contents. By signing below, I am fully agreeing to all the above statements.** (Please let me know if you would like a copy of this document for your records.)

_____

**Client Signature** **Date**

# Release and Liability Waiver

**Please read carefully before signing and ask for clarification on any portion that you do not understand. Please initial after each statement indicating that you understand and agree to the statement:**

1. I understand that Yoga Therapy incorporates both cognitive and physical approaches, and that there is an inherent risk when participating in physical activities. I agree to let the therapist know of any physical limitations I might have, or any physical activities I do not wish to participate in.

Initials: _____

2. I hereby release Stephanie Gutzmer, Wholistic Hearing Care, Ltd. and all other sponsoring agencies from responsibility for any injuries I may sustain as a result of participation in this program.

Initials: _____

I have read the above waiver and agreement and have fully understood its contents. By signing below, I am fully agreeing to all of the above statements.

_____

**Signature** **Date**

**I have received a Disclosure Statement.** _____
**Initial**

**I have been given the Notice of Privacy Protection** _____
**Initial**