



Yoga Pointe, Inc

2539 South Florida Ave

Lakeland, FL 33803

Yoga Teacher: \_\_\_\_\_

**YOGA PRIVATE INTAKE FORM - CONFIDENTIAL INFORMATION** Please take some time and tell us about yourself to make our practice together as safe, comfortable, and enjoyable as possible. If at any time you have questions regarding your session, please let us know. Please know that I strongly encourage you to freely express yourself during your yoga sessions. Let me know of any postures or practices which you find uncomfortable and what I may do to further enhance your practice of yoga.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Phone: \_\_\_\_\_ Email address: \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Number \_\_\_\_\_

If so, what styles have you practiced (circle all that apply): Hatha Ashtanga Vinyasa/Flow Iyengar Power Anusara Bikram/Hot Forrest Kundalini Yin Gentle Restorative Other \_\_\_\_\_

2. If you do yoga, what do you like about practicing?

3. What goals and benefits are you seeking for your yoga practice? (circle all that apply)

Strength training Flexibility Balance Stress relief Address health concern Alternative therapy Asana (postures) Pranayama (breath work) Meditation Yoga Philosophy Improve fitness Weight management Increase well-being Injury rehabilitation

Other:

PHYSICAL HISTORY

4. Are you currently seeing a healthcare professional? If yes, please list names and reason/treatment.

5. Please review this list and check those conditions that have affected your health either recently or in the past.

\_\_\_ broken/dislocated bones

\_\_\_ muscle strain/sprain

\_\_\_ arthritis, bursitis

\_\_\_ disc problems

\_\_\_ scoliosis

\_\_\_ back problems

\_\_\_ osteoporosis

\_\_\_ pregnancy

\_\_\_ surgery

\_\_\_ seizures

\_\_\_ stroke

\_\_\_ heart conditions, chest pain

\_\_\_ auto-immune condition\*

(\*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

\_\_\_ diabetes type 1 or 2

\_\_\_ high/low blood pressure

\_\_\_ insomnia

\_\_\_ anxiety/depression

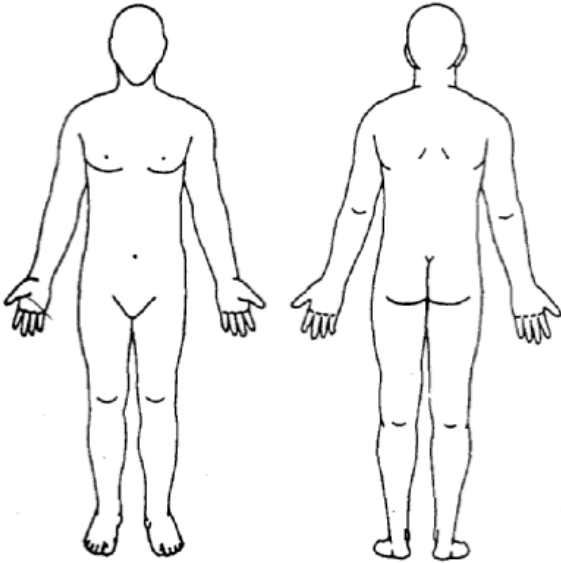
\_\_\_ asthma, short breath

\_\_\_ numbness, tingling anywhere

\_\_\_ cancer (explain below)

Other/ Explain:

Please provide details of any of the above conditions:



Please draw a circle around the problem area  
and indicate the appropriate letter:

T - tension

N - numbness

C - cramping

P - pain

#### LIFESTYLE & FITNESS

6. How do you rate your current level of activity? (circle one)

Sedentary/Very inactive    Somewhat inactive    Average    Somewhat active    Extremely active

7. Describe your current workout program: (Ex: cardio, weights, walking etc, or specify none)

8. Workout frequency and duration: (ex: daily, few times a week, monthly, etc.)

9. On a scale of 1-5, (1 is lowest, 5 is highest) how would you rate your level of stress? 1    2    3    4    5

10. On a scale of 1-5, (1 is poorest, 5 is best) how would you rate your quality of nutrition? 1    2    3    4    5

PLEASE READ THE FOLLOWING INFORMATION AND SIGN BELOW:

I understand that yoga includes physical movements as well as an opportunity for relaxation, stress re-education and relief of muscular tension. As is the case with any physical activity, the risk of injury, even serious or disabling, is

always present and cannot be entirely eliminated. If I experience any pain or discomfort, I will listen to my body, adjust the posture and ask for support from the instructor.

Yoga is not a substitute for medical attention, examination, diagnosis or treatment. Yoga is not recommended and is not safe under certain medical conditions. I affirm that I alone am responsible to decide whether to practice yoga. I hereby agree to irrevocably release and waive any claims that I have now or hereafter may have against Yoga Pointe, Inc. and its Independent Contractors.

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Signature

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Date