niuyoga
Student Intake Form

Name:_____ Today's Date: _____

Date of Birth:_____

Email:_____

Cell Phone:_____ Home Phone:_____

Mailing Address:_____

Emergency Contact:_____ Relationship:_____

Cell Phone:_____ Home Phone:_____

Your Activities

What physical activities and/or sports other than yoga do you participate in for exercise and enjoyment? _____

_____

_____

Have you practiced yoga before? _____ For how long?_____ How long ago? _____

IF YES:

Please provide a description of your daily yoga practice.

_____

_____

Which postures do you practice during a typical session?

_____

_____

Are there postures that you avoid and what are they? _____

_____

Do you meditate? _____ Do you practice pranayama (yogic breathing)? _____

What is your favorite style of yoga to practice and why is it your favorite? _____

_____

_____

IF NO:

What brings you to yoga?

_____

_____

_____

General Health Information

*Have you ever been told that you have heart disease, high blood pressure or stroke? _____

*Have you ever had any surgery or procedure performed on any blood vessel, heart valve or do you have a pacemaker? _____ If yes, which & when? _____

*Are you taking any prescription medication for blood pressure, heart disease, to thin the blood or for the prevention of stroke? _____

*Do you have any chronic or previous injuries? _____

*If so, when did your injury occur? _____

*How did you injure yourself? _____

*What area of your body is affected by your injury? _____

*What activities relieve your pain/discomfort? _____

_____

*What activities of daily living (i.e., dressing, bathing, cooking, cleaning, walking) are you unable to do because of any injury, pain or limitation? _____

*Have you received physical therapy in the past for an injury? ___ Yes ___ No

*Are you currently pregnant or trying to get pregnant? _____

*If you are pregnant, how many weeks are you? _____

*Is this or will this be your first pregnancy? _____

*In addition to the concerns mentioned above, are you currently under a doctor's care for a medical or psychological condition or injury and/or are you taking medication(s) for a chronic condition/illness? _____

If you answered "Yes" to any of the above questions, please list the condition(s) and any medications you are taking:

Condition *Medication/Treatment*

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Is there anything else you would like to mention? _____

_____

I am committed to protecting your privacy. Your and or your child(ren)'s personal and medical information will not be shared with anyone under any circumstances unless you specifically direct me to do so. All information that you provide on this input form or otherwise will be held in strict confidentiality.