

# Raleigh NC Yoga Confidential Client Information

THE DETAILS IN THIS PACKET ARE KEPT BY RALEIGH NC YOGA, LLC ONLY FOR THE PURPOSE OF DESIGNING YOUR YOGA THERAPY PRACTICE. YOUR INFORMATION IS KEPT COMPLETELY CONFIDENTIAL AND NEVER SHARED .

Date: \_\_\_\_\_

Name: \_\_\_\_\_  F  M    DOB: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_    Other Phone: \_\_\_\_\_

Other Phone: \_\_\_\_\_    Email: \_\_\_\_\_

Marital Status:     M  S  W  D    Number of children: \_\_\_\_\_

Age: \_\_\_\_\_    Height: \_\_\_\_\_    Weight: \_\_\_\_\_

Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_    Phone: \_\_\_\_\_

Whom may we thank for referring you to us: \_\_\_\_\_

Reason for care:  
(Check all that apply)

- Wellness/proactive care
- Imbalance
- Pain
- Disease
- Condition
- Other

If a condition,  
date first noticed: \_\_\_\_\_    Have you had symptom(s) before?     Yes\*  No

**\* IF YES, PLEASE EXPLAIN USING THE BACK OF THIS PAGE**

**Health History Information**    **Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Rate Your Digestion:**     Poor    Fair    Good    Excellent

**Indicate your frequency of:**

- Distention/ gas     Rare    Sometimes    Often    Most of the day
- Driving     Rare    Sometimes    Often    Most of the day
- Sitting     Rare    Sometimes    Often    Most of the day
- Standing     Rare    Sometimes    Often    Most of the day
- Work at computer     Rare    Sometimes    Often    Most of the day
- Carry heavy bag/child     Rare    Sometimes    Often    Most of the day

**List any current medications:** \_\_\_\_\_

**List exercise/physical activities:** \_\_\_\_\_

**List previous yoga experience:** \_\_\_\_\_

**List types of team/competitive sports:** \_\_\_\_\_

**Indicate if you have experienced any of the following conditions:**

- Accidents/ falls    \_\_\_\_\_
- Surgery    \_\_\_\_\_
- Difficult birth    \_\_\_\_\_
- Other trauma to the body    \_\_\_\_\_
- Seizures/brain issues    \_\_\_\_\_
- Fatigue    \_\_\_\_\_
- Dizziness    \_\_\_\_\_
- Difficulty balancing    \_\_\_\_\_
- Muscle weakness    \_\_\_\_\_
- Insomnia    \_\_\_\_\_
- Headaches    \_\_\_\_\_
- Sciatica    \_\_\_\_\_
- Auto immune condition    \_\_\_\_\_
- Joint stiffness/swelling/pain    \_\_\_\_\_
- Neck stiff or painful    \_\_\_\_\_
- Hip pain    \_\_\_\_\_
- Pain in shoulder    \_\_\_\_\_
- Other muscle stiffness/pain    \_\_\_\_\_
- Scoliosis/spinal disc probs.    \_\_\_\_\_
- Low back pain    \_\_\_\_\_
- Flank/side pain    \_\_\_\_\_

**Indicate if you have experienced any of the following conditions:**  
*(continued)*

\_\_\_\_\_



**6. I agree to inform my instructor/teacher of any physical limitations, physical discomfort and/or injuries before or during classes, and I take full responsibility for nondisclosure.**

\_\_\_\_\_.

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

\_\_\_\_\_.

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Name \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Work # \_\_\_\_\_