PURRFECTLY PEACEFUL YOGA THERAPY

INTAKE FORM – CONFIDENTIAL INFORMATION

Thank you for choosing Purrfectly Peaceful Yoga Therapy. I am committed to creating a compassionate and healing environment for all of my clients. Please let me know if you have any questions about this form or our sessions.

Name:	
Date of Birth:	Age:
Cell Phone:	Work or Home Phone:
Email Address:	
Emergency Contact:	Emergency Phone:
Address:	
City/State/Zip:	Occupation:
Referred By:	
Gender Pronouns (Check and/or specify)	He/Him ☐ Her/She ☐ They/Them ☐ Other (Specify):
Racial or Ethnic Identity:	
Current Religious or Spiritual Practice:	
Sexual Orientation:	
Accessibility Needs (if any):	

Yoga Therapy Goals & Physical Assessment:

Current reason for seeing a yoga therapist:

Goals for yoga therapy sessions:

List current and previous health conditions including medical diagnosis:

Problem List/Past Medical History:

___ Abdominal Pain
___ Abnormal Vaginal Bleeding
___ Anxiety/Depression
___ Arthritis/Bursitis
___ Asthma/Short of Breath
___ Autoimmune Disease
___ Back Pain/Problems
___ Bladder Issues
___ Broken Bones
___ Bruising
___ Cancer (explain below)
___ Colitis, Ulcerative
___ Cranial Instability
___ Diabetes
___ Dizziness
___ Headaches/Migraines
___ Heart Conditions
___ High/Low Blood Pressure
___ Insomnia
___ Irritable Bowel
___ Joint Pain
___ Irritable Bowel
___ Mast Cell
___ Numbness/Tingling
___ Osteoporosis
___ POTS
___ Scoliosis
___ Seasonal Allergies
___ Skin stretchiness/scarring issues
___ Sleep Disorder
___ Sprains
___ Stroke
___ Teeth/Gum Issues
___ Tendinitis
___ TMJ Syndrome

Other (please explain):_____
_____
_____

Previous surgeries & dates (month/year):

Any known allergies (food, pollen, dust, meds) and if so please list and explain reaction:

Recent accident/injuries & approximate date of occurrence:

How many months have you been experiencing this issue(s):

_____1 Month _____ 3 Months _____ 6 Months _____9 Months

_____1 Year _____ # of years

Has your illness/issue progressed since it began:

_____ Stable _____ Gradual Improvement _____ Rapid Improvement

_____Fluctuates _____ Gradual Worsening _____ Rapid Worsening

What are your symptoms:

Are your symptoms:

_____Mild _____Moderate _____ Severe _____Very Severe

What would you rate your level of pain (1 being mild to 10 being severe) from 1-10? _____

How often are you having pain:

_____Daily _____Less than once a week _____Several times a week

_____Several times a day _____Most or all of the time

Who else are you seeing you your health concerns or for general health & welfare? How often do you see them?

Would you like PPY Therapy to share your information with your healthcare providers? If so, please provide contact names and numbers:
Please list current medications and reason for taking them:
Please list any nonprescription supplements or vitamins:
Please list additional past medical history or problems (such as illness, trauma, abuse, addictions, etc:
Do you have a family history of the current or previous medical issues/problem: _____Yes _____No If yes, please explain:
Do you smoke or have you ever smoked: _____Yes _____No

Lifestyle and Fitness/Yoga Goals:

Assign percentages to the following activities as it relates to your daily routine:

_____Sitting _____Driving _____Standing _____Desk Work

_____ Lifting _____Lying Down

Do you have a regular daily schedule or does or does it change from day to day:

Please describe your energy level:

If it changes throughout the day then please explain when you feel:

_____Most energized

_____Most tired

_____When you most productive

How do you rate your current lifestyle activity level:

_____Sedimentary

_____Somewhat inactive

_____Average

_____Somewhat active

_____Very active

What are your favorite physical activities:

Have you done yoga before?

_____No _____Yes _____Date of last class/practice

Personal interests as it pertains to yoga:

_____Asanas (physical practice)

_____Pranayama (breathwork)

_____Meditation

_____Philosophy

_____Eastern energy systems

Please rate your stress level (from 1-10) with 1 being little stress, 5 being moderately stressed, and 10 being very stressed:
Please explain the requirements/stress of your occupation:
Are you married or living with someone? _____Yes _____No
Do you have children? If so, how many and their ages:

How often do you drink alcohol:	How often do you drink caffeine (any):
____Never	____ Never
____ Less than once a week	____ One cup a day
____ Several times a week	_____ 2-3 cups a day
____ More than once a day	_____ 4 or more a day

Do you smoke cigarettes? _____Yes _____No If yes, how many a day: _____
Do you smoke marijuana? _____Yes _____ No If yes, how many times a day_____
How would you rate your usual energy level? _____Very low _____Low _____Moderate _____High _____Very high
Are you regularly experiencing the following? Check all that apply. _____ Anxiety _____Fear _____Panic _____Depression _____Anger _____Irritability _____ Panic _____ Loneliness _____ Suicidal Tendency _____High Stress _____ Lack of energy _____ Lack of memory _____ Critical/Judgmental _____Indecisive _____ Self-destructive _____Overwhelmed _____ Over Attachment _____Jealous/Envy

Daily Routine:

What time do you wake up:_____ Do you consider this early:_____
What time do you go to bed:_____ Do you consider this early:_____
Do you nap during the day: _____Yes _____No
How would you explain your quality of sleep: _____Sound, fall asleep quickly & wake up feeling rested _____Light, wake up frequently _____Normal, 6- 8 hours _____Heavy, sleep too long and have a hard time waking _____ Interrupted, not enough sleep
Do you wake up feeling: _____ Refreshed _____ Slightly Tired _____ Moderately Tired _____ Very Tired What position do you sleep: _____ On your back _____Left Side _____Right Side _____ On your stomach

When do you turn off digital media:_____

Do you have a daily routine (go to bed at a certain time, wake at a certain time, eat meals on schedule and exercise regularly):

_____ Regular _____ Somewhat Regular _____ Irregular

How often do you experience bowel movements:

_____Once or twice a day _____ Once a day _____Once every 2-3 days

Do you experience the following:

_____ Diarrhea _____Blood in stools _____Mucus in stools ___Unusual color/odor

Do you alternate between constipation and diarrhea: _____ Yes _____ No

Do you have painful and/or difficult bowel movements: _____Yes _____ No

What is your stool consistency:

_____ Loose _____ Soft _____Hard _____ Pellets _____ Dry

What is your stool density:

_____Floats _____ Sinks _____Scatters

What is your stool color:

_____Clay/reddish brown _____Brown _____Other:_____

How much water do you drink in a day: _____ cups or ounces

How many cups of non-caffeinated beverages do you during in a day: _____

What type of beverages do you drink:

_____Milk _____Juice _____Herbal Tea _____ Other

After eating do you experience:

_____Heaviness _____ Bloating _____Low energy _____Indigestion _____Gas

_____ Belching _____Nausea _____Vomiting

What is your typical hunger level before you eat:

_____ Very hungry _____Somewhat hungry _____Not Hungry _____ Full_____

Do you suppress or delay any of the following:

_____Sleep _____Bowel Movements _____Gas _____ Urination

_____ Yawning _____ Burping _____Thirst _____Hunger _____Sneezing

_____ Crying _____ Semn

Do you travel frequently: _____ Yes _____ No

Do you practice dry brushing or self oil massage daily: _____ Yes _____No

Exercise:

How often do you exercise: _____Daily _____ Once a week _____ Twice Weekly _____Three/Four Times _____ Every day _____ Not at all
How long do you exercise:_____
What type of exercise do you do:
How would you rate the intensity of your exercise: _____ Light _____ Moderate _____Vigorous
Do you experience any of these symptoms during or after exercise: _____Light-headedness _____ Muscle cramps _____ Short of breath ___Weak/shakey

Eating Habits:

Please explain what you eat normally for the following meals: Breakfast _____ Lunch_____ Dinner_____
Do you snack and if so at what times & what do you typically eat: _____
Which meal is typically the largest of the day: _____Breakfast _____Lunch _____Dinner
What are your eating habits: _____Slow and with attention to the meal _____ Talk a lot during the meal _____ Watch television or social media while eating _____ Eat very fast _____ Never sit for complete meal _____ Pick at food or push it around your plate
What type of diet do you have: _____ Vegan (Plant based without any meat biproducts) _____ Lacto-ovo Vegetarian (Plant based w/no meats, but allow eggs & dairy) _____ Lacto Vegetarian (Plant based with dairy) _____ Pescatarian (plant based, but allow for seafood, eggs, & dairy) _____ Flexitarian (eat a lot of plant based foods, but allow meat & biproducts in your diet _____ Other, please explain:_____
Non-vegetarian and eat: _____Beef _____ Pork _____ Poultry _____Seafood _____Eggs _____Other

What types of tastes do you crave: _____Sweet _____ Salty _____ Sour _____ Bitter _____Spicy _____Starches _____Oily
What foods create discomfort when you eat them:
Do you eat when you are tense/ stressed/anxious/depressed? _____Yes _____No What do you eat when you feel this way:_____

Social History:

Are your family relationships loving and healthy:
What would you change:
Are your personal relationships healthy and nurturing:
What would you change:
What challenges are you facing in relationships, career, etc.:
What emotions do you have a difficulty expressing:
Do you enjoy your career?
Do you volunteer?
What brings you the most happiness?
Where do you see yourself in one year:
Where do you see yourself in five years:
Where do you see yourself in ten years:
If you could change one thing in your life, what would it be:
How would you rate your spiritual life: _____ Very satisfying _____ Satisfying _____Neutral _____ Non-existent
During your childhood did you experience one of the following: _____ Emotional Abuse _____Verbal Abuse _____ Physical Abuse _____Sexual Abuse _____ Other Trauma _____ None

Miscellaneous

Do you have a meditation practice and if so explain:
Do you regularly practice and if so please explain methods/types (Restorative, Vinyasa, Ashtanga, Aerial, Hatha, etc.) What is your favorite type of yoga: _____
What type of weather/climate do you prefer: _____Hot _____Cold _____Humid _____Dry What type of landscape do you prefer: _____Desert _____Prairie/Plains _____Mountains _____Forests What type of geographical lifestyle do you prefer: _____City _____Small Town _____Country