FIVE RIVERS
YOGA THERAPY

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Client Intake Form

Please complete this prior to your Initial Session. All information will be kept confidential.

Required fields marked with *

1. Today's Date:
2. **Name*:**
3. Mailing Address:
4. Telephone:
5. **Email***:
6. Birth Date:
7. Occupation:
8. Emergency Contact:
9. How did you hear about Five Rivers Yoga Therapy?
10. **What is the primary condition(s) that you are seeking support for through Yoga Therapy?***
11. What is your main intention or goal for Yoga practice?

Medical History

Do you have or have you had:

Now	Past	Condition
____	____	Allergies
____	____	Anemia
____	____	Anxiety
____	____	Arthritis
____	____	Artificial joints
____	____	Asthma
____	____	Back problems
____	____	Balance problems
____	____	Bladder/bowel problems
____	____	Breathing problems
____	____	Broken bones
____	____	Cancer
____	____	Chest pain
____	____	Chronic fatigue
____	____	Depression
____	____	Diabetes
____	____	Dizziness, vertigo
____	____	Epilepsy
____	____	Fibromyalgia
____	____	Glaucoma
____	____	Headaches
____	____	Hearing difficulties
____	____	Heart problems
____	____	Hernias or ruptures
____	____	High blood pressure
____	____	Hypoglycemia
____	____	Hysterectomy
____	____	Joint problems, dislocation or instability
____	____	Joint replacement (hip, knee)
____	____	Joint problems, swelling
____	____	Low blood pressure
____	____	Low libido
____	____	Menopause challenges
____	____	Motor vehicle or traumatic accidents
____	____	Neck pain
____	____	Osteoporosis/osteopenia
____	____	Pinched nerves
____	____	Pregnancy
____	____	Rheumatoid arthritis
____	____	Sciatica
____	____	Seizures
____	____	Visual difficulties
____	____	Other chronic conditions
____	____	Other:

Have you had any surgeries? Yes/No

If Yes, please describe what and when:

Broken bones or fractures? Yes/No

If Yes, please describe what and when:

Major injuries or accidents? Yes/No

If Yes, please describe what and when:

Please describe in detail any acute or chronic pain you experience:

Have you been under the care of a licensed health care professional in the past year? Yes/No

If Yes, for what?

Please list any medications and supplements you are currently taking:

How is your digestion? Please describe:

How is/are your (*please circle all that apply):*

Bowel movements: Great/Normal/Constipated/Diarrhea

Urination: Frequent/infrequent/Normal

Gas/Bloating: Yes/No

How is your nutrition? Excellent/Good/Fair/Poor

What time and types of food do you eat for:

	Time	**Foods**
Breakfast:	_____	_____
Lunch:	_____	_____
Dinner:	_____	_____
Snacks:	_____	_____

Any current or past problems with chronic eating disorders or other food-related issues? Yes/No

If Yes, please describe:

Do you have allergic reactions to any foods or other substances? Yes/No

If Yes, please list:

How many **cups per day** do you drink of:

_____ Water

_____ Non-caffeinated beverages: herbal tea, milk, juice, soda, other

_____ Caffeinated beverages tea ,coffee, soda

_____ Alcoholic beverages

_____ Other

Any current or past problems with smoking, alcohol use, addiction or substance abuse? No/Yes

If Yes, please describe:

How would you describe your energy level? (*Circle all that apply.*)

High/Medium/Low/Stable/Variable/Other

How is your stress level? High/Medium/Low

If High or Medium, what types of situations do you find stressful?

If High or Medium, what are some of the ways you find most effective for releasing stress?

Do you awaken from sleep feeling rested? Yes/No

If No, please explain:

Average # of hours sleep? _____

How is your breathing? _____

What is your state of mind most of the time?

How would you describe your spiritual life?

What is your level of physical activity and exercise? None/Low/Medium/High

Please describe:

What do you do to bring joy, peace, health and balance into your life?

What is your experience with Yoga? None/ A Little/Some/A Lot

If Some/A Lot: How often do you practice?

If A Little/Some/A Lot: What have you found most beneficial?

If A Little/Some/A Lot: What have you found most challenging?

If A Little/Some/A Lot: Have you had any previous Yoga injuries? Yes/No

If Yes, please describe:

What is your experience with Meditation? None/ A Little/Some/A Lot

If Some or A Lot, please describe:

If Some or A Lot, how often do you practice?

If A Little/Some/A Lot: What have you found most beneficial?

If A Little/Some/A Lot: What have you found most challenging?

Do you have any other comments, questions, or concerns?

Agreement: PLEASE READ CAREFULLY BEFORE SUBMITTING/SIGNING.
[Form created: 2/11/2016, updated: 7/7/2016]

1. DISCLOSURE STATEMENT: Health Freedom Act, California SB-577. I understand that Rachel Lanzerotti is a practitioner of Yoga Therapy. Yoga Therapy may include breathing practices, movement, meditation and daily mindfulness, and lifestyle coaching. As part of Yoga Therapy, Rachel may suggest Ayurvedic practices, which shift the body towards health and balance. Ayurveda is an Indian mind-body health system and uses dietary recommendations and herbal remedies. Rachel is not a licensed physician, nor are Yoga Therapy services licensed by the state. Rachel Lanzerotti has certification in Yoga Therapy from the Essential Yoga Therapy Therapist Training Program, in Fall City, WA and is a member of the International Association of Yoga Therapists (IAYT). Her method of treatment, Yoga Therapy, is an alternative or complementary form of healing arts. Under Sections 2053.5 and 2053.6 of California's Business and Professions Code, I understand that Rachel can offer me these services, subject to requirements and restrictions that are described fully in the document entitled "California State Senate Bill SB 577 - What It Means for Patients." If I ever have any concerns about the nature of my treatment, I will discuss them with Rachel. I understand that she recommends that I inform my medical doctor or other primary care provider that I am participating in Yoga Therapy, especially if I am under medical care for any condition. California state law requires that I acknowledge receipt of this information and receive a copy. Rachel will keep the original in her records for at least 3 years.

2. I understand that I must judge my own capabilities with respect to practicing yoga and meditation. I recognize that yoga may involve physical exertion. By my participation, I agree to assume full responsibility for any risks, injuries, or damages, known or unknown that I might incur in such practice.

3. I understand that it is my responsibility to consult with a physician prior to and regarding my participation in yoga and meditation. I represent and warrant that I have no medical condition that would prevent my full participation. I acknowledge that it is my responsibility to inform the instructor, when I begin a class, of any injury or other condition that might affect my ability to participate, and to inform the instructor immediately if an injury occurs during class. During a class, if at any time I feel that instructions or class activities present any risk of injury to me, or if I feel tired or otherwise unable to perform class activities, I will inform the instructor and refrain from activities in question.

4. If I am pregnant, I assert and attest that I am participating in yoga and/or meditation classes, with my doctor’s explicit approval. I acknowledge that I am participating in yoga and/or meditation classes at my own risk, and that it is my responsibility and my doctor’s responsibility to determine safe parameters of my participation, whether or not I inform the class instructor that I am pregnant.

By signing this form, I acknowledge that participation in yoga and/or meditation classes exposes me to a possible risk of personal injury. I forever release, and waive, and discharge claims based on, and covenant not to sue based on, any injury sustained in or in connection with yoga and/or meditation classes operated or taught by Rachel Lanzerotti and her agents or Five Rivers Yoga, LLC (Released Parties). I knowingly, voluntarily, and expressly make such release, waiver, discharge, and covenant, for the benefit of Released Parties, as a condition of participating in the yoga and/or meditation classes in question, and do so on behalf of myself, my spouse, and successors, heirs, assigns, and creditors.

_____ _____

Signature Date

_____

Printed Name