|  |  |  |  |
| --- | --- | --- | --- |
| **Client name:** |  | **Date of Birth:** |  |
| **Address Line 1** |  | **Address line 2** |  |
| **Town** |  | **Post code** |  |
| **Gender** |  | **Marital Status** |  |
| **Mobile (or Main)** |  | **Emergency contact**  |  |
| **Occupation** |  | **Email Address** |  |
| **Referred by** |  | **Date of First Appointment** |  |
| **Yoga Therapy**  |
| What conditions are you interested in yoga therapy for? **Please list in order of priority importance to you**.  |  |
| Do you have previous yoga experience?  | Yes / No. If yes, please describe: |
| What benefits do you hope to get from yoga therapy? |  |
| **Previous Treatment** |
| Have you seen, and are you currently seeing any practitioner(s) (including complementary practitioners)? | Yes / No If yes, please describe: |
| Are you currently taking any medication, herbs or supplements?  | Yes / No If yes, please list by condition: |
| Have you had time off work for this condition? | Yes / No If yes, please describe: |
| **Health Status – For multiple choice, please circle, bold, or delete as relevant** |
| **Height** |  | **Weight** |  |
| **Energy level** | Good / moderate / poor / erratic | **Appetite** | Good / moderate / poor / erratic |
| **Sleep Onset** | Fast / takes time / erratic | **Sleep Quality** | Good / moderate / poor / erratic |
| **Bowel Movement** | Regular / irritable / constipated / erratic | **Menstruation** | Normal / Menopause / Problematic (describe) |
| **Are you pregnant? /****Age(s) of children** | Yes / No   | **Muscle / joint pain / stiffness** | No / Yes (describe) |
| **Breathing** | Asthma / Other (describe) | **Heart / Circulation / Blood Pressure** | High BP / Low BP / Arrhythmia /Heart Attack / Other: |
| **Nervous System** | Stroke / Fainting / Dizziness / Numbness Pins & Needles /Other | **Headaches (Give frequency)** | Migraine / Tension / other |
| **Problems with eyes /ears /nose /mouth?** | No / Yes (describe) | **Skin problems** | No / Yes (describe) |
| **Typical diet** |  | **Mealtimes** | Regular / erratic / eat late in the evening |
| **Do you drink alcohol? How many units/week?** | Yes / No | **Do you smoke? How much?** | Yes / No |
| **Do you drink caffeine? How much per day?** |  | **Exercise Type & frequency** |  |
| **Family Medical History** |
| **Please list any chronic health conditions:** | Mother:  |
| Father: |
| Grandparent: |
| Sibling: |
| **Please list any previous or current events:** | Surgeries: |
| Accidents/Injuries:  |
| Illness: |
| **Mind & Emotions**Worry /anxiety / stress depression/ hyperactive irritable/other  |  |
| The above information is correct and complete and I am willing to provide further information in follow up sessions. The signature below covers data privacy and liability waver statements on page 3 of this form.**Signed and date (Print name )****Data Privacy statement:** Please note that your personal data will be stored and used in accordance with our Privacy Statement below.By providing us with your personal data, including sensitive personal data, such as information on your health, you consent to the collection and use of any information you provide in accordance with the above purposes and this privacy statement. By signing this form you are agreeing to the use of the information for these purposes. We will not be sharing your data with third party supplier without your explicit consent. We will all reasonable endeavours to ensure that you provide personal information in a secure and confidential environment and when the information is no longer needed it will be destroyed or permanently rendered anonymous. We will only use your personal information for direct marketing purposes of yoga therapy related services. By signing this form, you agree that you are happy to receive this information. If you change your mind at any time in the future, please write to above email address to request removal form the distribution list. You may request details of personal information which we hold about you under the Data Protection Act 1998. A small fee may be payable. If you would like a copy of the information held on you, please write to the address as per above. If you believe that any information we are holding on you is incorrect or incomplete, please email us as soon as possible, at the above address. We will promptly amend any information found to be incorrect. To prevent unauthorised access, maintain data accuracy, and ensure the correct use of information, we have put in place appropriate physical, electronic, and managerial procedures to safeguard and secure the information we collect.**Liability release:** I understand that yoga includes physical movements as well as an opportunity for relaxation, stress re-education and relief of muscular tension. Participation in yoga therapy sessions includes, but is not limited to, participation in meditation techniques, yogic breathing techniques, and performing various yoga postures. Yoga postures, or asanas, are designed to exercise every part of the body―stretching and toning the muscles and joints, the spine and the entire skeletal system. They also work on the internal organs, glands and nerves. Yoga incorporates sustained stretching to strengthen muscles and increase flexibility. Yoga is an individual experience. As is the case with any physical activity, the risk of injury, even serious or disabling, is always present and cannot be entirely eliminated. My signature acknowledges that I understand that in yoga session I will progress at my own pace. If I experience any pain or discomfort, I will listen to my body, adjust the posture and ask for support from the teacher. I will continue to breathe smoothly. If at any point I feel overexertion or fatigue, I will respect my body’s limitations and I will rest before continuing yoga practice. Yoga Therapy is not a substitute for medical attention, examination, diagnosis or treatment. Yoga is not recommended and is not safe under certain medical conditions and I can affirm that I am physically fit to participate in yoga therapy sessions and where appropriate consulted medical doctor to verify that I have no limitations to take part. 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 ***Vera Dubrovina-Thompson***.By signing my name in this form, I acknowledge that participation in yoga therapy sessions exposes me to a possible risk of personal injury. I am fully aware of this risk and hereby release ***Vera Dubrovina-Thompson*** from any and all liability, negligence or other claims arising from or in any way connected with my participation in yoga therapy sessions. My signature further acknowledges that I shall not now or at any time in the future bring any legal action against ***Vera Dubrovina-Thompson***; and that this waiver is binding on me, my heirs, my spouse, my children, my legal representatives, my successors and my assigns. **My signature is binding to this liability waiver from the date of the signature on page 2 of this document.** |