Yoga Therapy

New Client

Questionnaire

INSTRUCTIONS FOR YOUR FIRST YOGA THERAPY CONSULTATION

Thank you for giving thoughtful consideration as you complete this New Client Questionnaire. You will have ample opportunity to address any concerns that require more detail during your appointment.

Required for your first appointment:

- The completed New Client Questionnaire

Please also bring/wear the following:

- Comfortable clothing

Client confidentiality will be observed under all circumstances

If you do have any questions, please contact me on 01722658066 or email: sharon@namastehathayoga.co.uk

YOGA THERAPY
New Client Questionnaire

Client confidentiality will be maintained at all times. The information provided on this questionnaire may only be disclosed with the express written consent of the individual named herein or, if under the age of 18, his or her legal guardian

Please allow 25-30 minutes to complete this questionnaire. Please answer the questions below as thoroughly as possible so that the best possible assessment can be made and a realistic and workable plan can be developed for supporting you in reaching your health goals. Your answers to personal questions such as relationship status, religion etc. are important as they provide helpful context for establishing a productive partnership with you. That said, please answer ONLY the questions you are comfortable answering

Today's Date:

Contact Information			
Name		Address	
Phone		Email	
Mobile		Best time of day to reach you	
Preferred contact method			

Demographic Information					
Gender		Date of Birth		Age	
Height		Weight (lbs)		Ethnicity	

Emergency Contact					
Name		Relationship		Phone	

Occupation & Interests					
Occupation		How Long?		Satisfied?	

Relationship Information			
Status		Partner's Name	

Personal Information	
Education:	
With whom (persons or animals) do you share your home	

Does your doctor/healthcare practitioner know that you are participating in Yoga Therapy? **Yes** **No**

What are your primary reasons for coming to Yoga Therapy?

1.

2.

3.

Please place an “X” next to anything you are currently experiencing. Issues that you had previously, but now longer have, mark with a “P”

Musculoskeletal	**Cardiovascular**	**Neurological**	**Endocrinological**
Neck/Back/Joint Pain	High Blood Pressure	Seizure	Low Blood Sugar
Stiffness	Low Blood Pressure	Headache	HBS/Diabetes
Fibromyalgia	Heart Palpitations	Migraines	Thyroid Issues
Osteoporosis	Heart Murmur	Insomnia	**Gynaecological/Urological**
Arthritis	**Circulatory**	Depression	Breast Issues
Accidents (Physical Trauma)	Bruise Easily	Anxiety	Possible Pregnancy
Overuse Syndrome (RSI)	Varicose Veins	**Gastrointestinal**	Positive Pregnancy (Which Trimester?)
Respiratory	Swollen or Painful Lymph Nodes	Diarrhoea	Peri/Post-Menopausal (Please circle)
Lung Issues	Poor Circulation	Constipation	Men: Prostrate Issues
Allergies			

Any Surgery, acute, or chronic illness? (Please list)			
Year	Description	Ongoing YES/No	Additional Information

How would you describe your overall health?

Is there now or has there historically been any illness or physical challenges which may impact your Yoga practice. Please share below:

Namaste Hatha Yoga

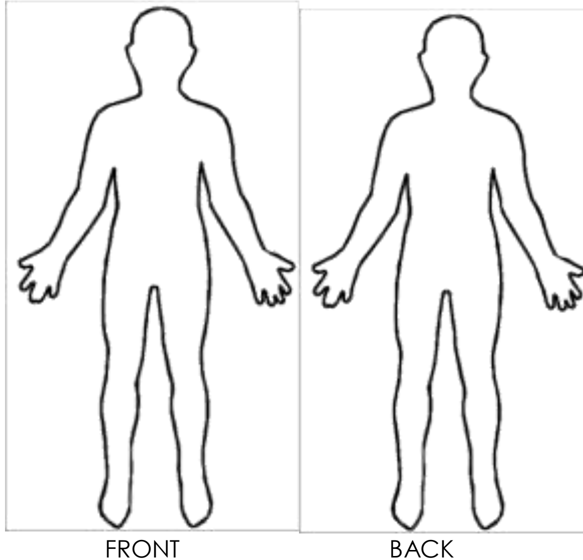
Medications (Over-the-Counter and Prescription)				
Name	Dosage	Frequency	Length of Time	Reason for Taking

Vitamins, Minerals or Herbal Supplements					
Name	Brand	Dosage	Frequency	Length of Time	Reason for Taking

Dietary Intake					
Do you eat regular meals?		How much caffeine do you consume in a day?		Do you use tobacco products?	
How much water do you drink in a day?		Any food sensitivities or intolerances?			

Namaste Hatha Yoga

Musculoskeletal System & Pain
On the following diagram, if you are experiencing any pain, please show the location of your pain/discomfort/stiffness and use the following symbols to describe it



Dull ●

Sharp ▬

Numb ✖

Does anything make your pain/discomfort better?			
Does anything make your pain/discomfort worse?			
Is there a daily pattern to your symptoms?			
Do you experience any of the following in your body? (Please tick any that apply)			
Stiffness	Weakness	Discomfort	Tightness
Decreased mobility	Excess mobility	Fatigue or decreased endurance	Limitation in Daily Activities

Energy Level				
Do you every experience your energy levels as any of the following (Please tick all that apply)				
High	Agitated	Chaotic	Low	Fatigue
Dull	Vibrant	Clear	Even	

Does your energy level fluctuate or is it constant?	
When is your energy at its highest?	
When is your energy at its lowest?	
What is your energy like when you first awaken?	
On average how long do you sleep at night?	
Do you struggle with insomnia or staying asleep?	

Emotions/Moods				
Are you having difficulty with any of the following? (Please tick all hat apply)				
Anxiety	Fear	Sadness	Depression	Grief
Despair	Negative self-talk	Anger	Other emotions	
Have you ever been diagnosed with a mental health condition **Y N** (if yes please tick all that apply)				
Anxiety	Depression	PTSD	Other	
How would you describe you overall mood and energy level?				

Namaste Hatha Yoga

Stress Response & Coping Strategies							
On a scale of 1-10 , with 1 being low & 10 being high, how stressful is your:							
Work		Social/family situation		Current health status		Life in general	

What strategies do you use to manage stressful and emotional situations?	
Do you have people in your life in which you can confide or go to for comfort	
Is there anything about your family relationships that you would like to share	
Which aspects of your life give you the most joy and pleasure	
Briefly describe your passions and interests	
How do you express yourself creatively	
Please describe your Spiritual Practices & Beliefs	

Significant Life Events	
Please list major events in the last ten years of your life and the dates they occurred. Include births, deaths, marriage, divorce, accidents, moves, job changes, illness and anything else you feel greatly impacted your life	
Date	Event

Physical Activity & Yoga Experience	
Describe your level of physical activity with regard to the following:	
Aerobic/Fitness Exercise	
Working with weights	
Other	
What is your previous experience with yoga, meditation, complimentary alternative health?	
Do you currently practice yoga? **Y N (If Yes, please answer the following)**	
How often & which style?	
Do you practice at a studio?	
Do you have a home practice?	
What do you find is the most challenging?	
Is there anything else you would like to ask me?	

Thank you for taking the time to complete this questionnaire