Duke Integrative Medicine

Therapeutic Yoga
Intake Form

Name ________________________________ **MRN #**_____________

Date of Birth ________________ Occupation__________________

Have you practiced yoga before? Y N

If Yes, for how long? Class ________________ Individual____________________

What brings you here today and what would you like from this session?

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Are you under the care of a medical professional or other health care provider? Y N

If yes, for what?

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Have you had any accidents or injuries, hospitalization or surgeries? If yes, please list:

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What medications have you taken in the past 6 months:_______________________________

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Are you involved in regular exercise or sports? If yes, please describe:

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Do you have any specific bodily discomfort? If yes, please describe.

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Have you ever had any of the following conditions/illnesses/problems?

o Spinal/Skeletal problems	o Headaches	
o Stroke history	o Cancer	o Fatigue
o Muscular Injuries/Disease	o Allergies/Asthma	o Dizziness
o Circulatory problems	o Respiratory Problems	o Heart condition
o Reproductive problems	o Infectious disease	o Skin disorders
o Pregnancy (delivery date)	o High/Low blood pressure	
o Arthritis	o Elimination problems	o Depression
o Anxiety	o Diabetes	o Insomnia

Please describe your health condition(s) or any other concerns below:

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Waiver of Liability

I understand that yoga involves some physical exertion and stretching, and I agree to take full responsibility for not exceeding my limits in the practice of yoga and for any injury or discomfort I might experience in the practice of yoga. I understand and accept that to properly teach and correct yoga technique, physical contact between student and instructor may be necessary. I consent to such contact and recognize that the instructor will apply any necessary contact in a professional manner.

Signature ____

Date ____

Thank you!