*All information given in this questionnaire is strictly confidential.*

*Today's Date:* _____

**CURRENT INFORMATION**

Full Name: _____ Date of Birth: _____

Address: _____ Age: ____ Gender Identity: _____

City/State/Zip: _____ Phone: _____

Email: _____ Referred by/hear of us? _____

Emergency Contact:_____ Phone: _____

Your physician: _____ Physician's contact: _____

Occupation: _____ Employer: _____

**CONCERN(S)**

What is the primary concern or goal for today? Have you had this in the past? If so, describe.

_____

_____

Please describe when the above began. What makes it better/worse? Its severity? Anything else…

_____

_____

_____

Is it? (circle one) getting worse getting better coming and going staying the same.

Please list other current concern(s):

Complaint Since Cause (if known)

_____

_____

_____

_____

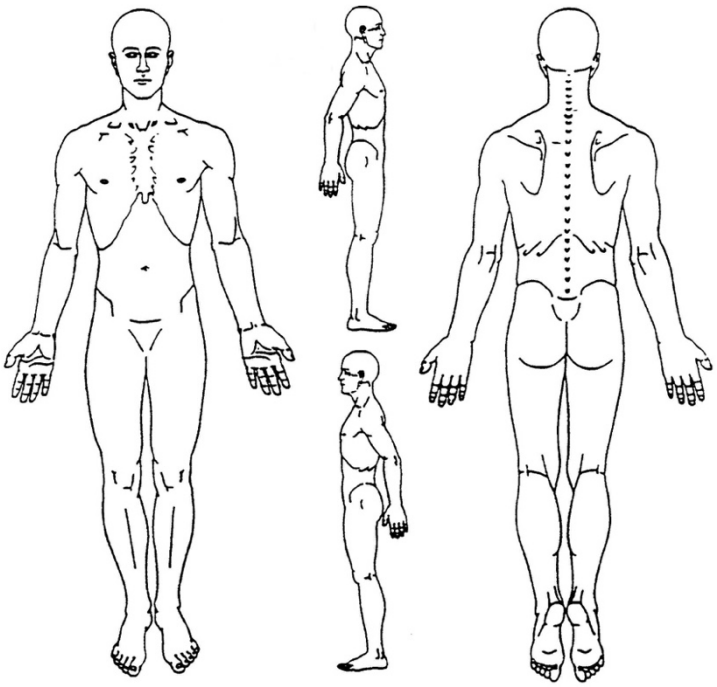
Do you have any specific body discomfort? If yes, please describe:

_____

_____

_____

If relevant to your visit, please circle any problem areas in the drawing and if possible, write a word to indicate the type of sensation or sensations there, such as tight, burning, numb, sharp pain, etc.



Do you perform any repetitive movement in your work, sport, yoga practice, recreation, home care, or other activities?

_____

_____

Are you seeing healthcare or other service providers for this issue/condition? (acupuncturist, physical therapist, massage practitioner)? (Yes/No) If so what is the diagnosis and what treatment if any have your tried?

_____

_____

Have you made any observations about your body, energy, mental or emotional life, beliefs and life philosophy in relation to this concern that you would like to share?

_____

_____

_____

_____

In what way(s) do you think yoga movement therapy can be of help to you?

_____

_____

**LIFESTYLE**

How many hours do you work each week? _____ Do you like your work? _____

Does your work stress or exhaust you? (Yes/No)

Do you generally get enough sleep? (Yes/No) Please describe: _____

Living Status: _____ Children: _____
(single/married/partner/divorced/widowed)

Are you currently or have you recently gone through an unusually stressful life change or event? (divorce, death in family, etc.)_____

_____

_____

What kind of diet do you eat?
___ Typical American ___Vegetarian ___Vegan ___Other:

Do you smoke cigarettes, cigars, marijuana? (Yes/No) If yes, list:_____

Do you drink alcohol? (Yes/No) If yes, how many drinks per week?_____

Do you use recreational drugs? (Yes/No) If yes, what and how often? _____

_____

What do you do to exercise and how often? (Ex. Walk 30 min/5 days a wk.)
_____

_____

What current or past sport, movement, dance, performance or art experience do you have?
_____

_____

What is your experience with yoga, meditation or similar eastern or wholistic practices?

_____

_____

_____

What are your biggest stressors? _____

Do you sit for long hours at a workstation, computer, and/or driving?
_____

_____

_____

List allergies to medicines, foods and environmental factors:
_____

_____

_____

List prescriptions or over-the-counter medications taken regularly:

_____

_____

_____

List vitamins, minerals, herbal preparations, tonics, supplements, flower essences, cell salts, homeopathic remedies or the like taken regularly:

_____

_____

_____

What do you do for fun and/or to relax?

_____

_____

**HISTORY**

List major illnesses and hospitalizations (operations, injuries/accidents and their dates):

_____

_____

_____

_____

_____

Have you ever been diagnosed with any of the following? If so, what year?

| | | | |
|---|---|---|---|
| ___Pneumonia | ___Skin boils | ___Obesity | ___Rheumatic fever |
| ___Tuberculosis | ___Eczema | ___Anemia | ___Measles |
| ___Asthma | ___Psoriasis | ___Blood transfusion | ___Mumps |
| ___Bronchitis | ___Parasites | ___Colitis | ___Chicken pox |
| ___Emphysema | ___Jaundice | ___Ulcer | ___Polio |
| ___High blood pressure | ___Hepatitis | ___Epilepsy/Seizure | ___Whooping cough |
| ___Low blood pressure | ___Gallstones | ___Mental breakdown | ___Diphtheria |
| ___Heart disease | ___Kidney stones | ___Arthritis | __Lyme's disease |
| ___Drug reaction | ___Bladder Infection | ___Cancer | ___Chronic Fatigue |
| ___Migraine | ___Hypoglycemia | ___Syphilis | ___fibromyalgia |
| ___Hives | ___Diabetes | ___Gonorrhea | ___Other: |

Please list and briefly describe any conditions, medical or otherwise, that may prohibit or limit your practice of yoga stretches, movements, breathing, meditation, introspection, or relaxation:

_____

_____

_____

List ailments of immediate family and indicate if deceased.

Mother: _____

Father: _____

Siblings: _____

Is there anything else you would like me to know?

_____

_____

_____

**Practice Information, Consent and Waiver**

**SYMT Practice Information**
Spanda® Yoga Movement Therapy is dedicated to the promotion of personal growth, wellbeing, and the prevention of chronic illness and injury whenever possible. Yoga is an ancient science that may benefit a person at every level of their being. Yoga Movement Therapy utilizes the time-tested techniques, principles and practices of yoga to support and facilitate natural mechanisms of healing, improved functionality, and increased self-awareness.

Dr. Jaime Stover Schmitt is certified as a yoga therapist (C-IAYT) by the International Association of Yoga Therapists (IAYT). She has been in private yoga therapy practice since 1985 and had been teaching yoga since 1976. Dr. Schmitt has participated in the writing and revision of the Yoga Alliance Standards for the training of yoga teachers and has been training teachers since 2003. She also serves on the IAYT's accreditation committee and participates in the writing and revision of the organizations' educational standards for the practice of yoga therapy. These standards are acknowledged worldwide in the training of yoga therapists. Dr. Schmitt also holds a doctorate in education, is certified at the level of ERYT500 as a yoga teacher and is also certified as a Somatic Movement Educator, Infant Developmental Movement Educator, Swedish and Shiatsu Massage Therapist, Personal Trainer, Group Fitness Instructor, Reiki Master, and Alexander Teacher.

**Fee and Billing**
All sessions at this location are conducted by Dr. Jaime Stover Schmitt, C-IAYT. The fee for the initial intake 75-minute session is $___. The fee for a 55-minute regular session is $____. Payment is due at the end of the session. Check and cash are preferred. If Paypal is used, an additional fee of $5 will be added.

Spanda® Yoga Movement Therapy (SYMT) does not bill on a monthly basis and does not bill insurance companies. SMYT can provide documentation with date, fee and description of session if requested.

**Cancellation**
There is no charge if appointments are cancelled 24 hours in advance. Cancellations within 24 hours of the scheduled time will be charged the full fee.

**Consent**
I, _____(print), voluntarily consent to engage in Yoga therapy and participate at my own level of comfort, knowing I can decide to discontinue at any time. I understand that Yoga therapeutic methods are based on holistic principles and practices of Yoga- its science and philosophy, and western scientific data and are not, as yet, considered standard treatments in mainstream medicine.
During Yoga sessions, I am aware I will engage in the activities designed for my concern. I agree to take responsibility by being mindful of what I can and cannot do and to inform my yoga therapist of limitations, symptoms, pain, discomfort, or other concerns that occur or change at any point. I understand that yoga involves both cognitive and physical elements and there is inherent risk when undertaking physical activity.
I realize Yoga therapy is designed to benefit my concern, but that success is not be guaranteed. I acknowledge I must take an active role in performing the recommendations given for them to be affective.

I am aware that my Yoga therapist is not a licensed physician, that Yoga therapy is complementary to licensed healing arts, and its practices are not currently licensed. I understand the qualifications of my Yoga therapist are shown above, and that my Yoga therapist is certified by the International Association of Yoga Therapists, which is the highest level of yoga expertise for therapeutic yoga practice acknowledged worldwide.
I acknowledge that it is my responsibility to consult with my physician and obtain his or her consent prior to beginning yoga therapy. I also understand I have been advised to consult a physician for any health problems if I have not done so. I recognize it is my responsibility to ascertain that there is no medical reason preventing me from any specific practice.
I realize that touching, guiding movement, or positioning my body may be necessary and I expressly consent to such physical contact. If I do not wish to be touched, I will initial the consent form here ( ) to notify the therapist, so a joint decision can be made about continuing the practice with this limitation.

**Waiver**
I hereby release Dr. Jaime Stover Schmitt, Spanda® Yoga Movement Therapy, and all other sponsoring agencies from responsibility for any injuries I may sustain as a result of participation in this work.

I understand that I am encouraged to ask questions and discuss my progress with the therapist at all times, and that I have read the above, understand it, and engage in this practice of my own volition.

_____ _____
(Name) (Date)

_____
(Signature)

If under 21, legal guardian's name: _____

Legal guardian's signature: _____