

*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.

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

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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)

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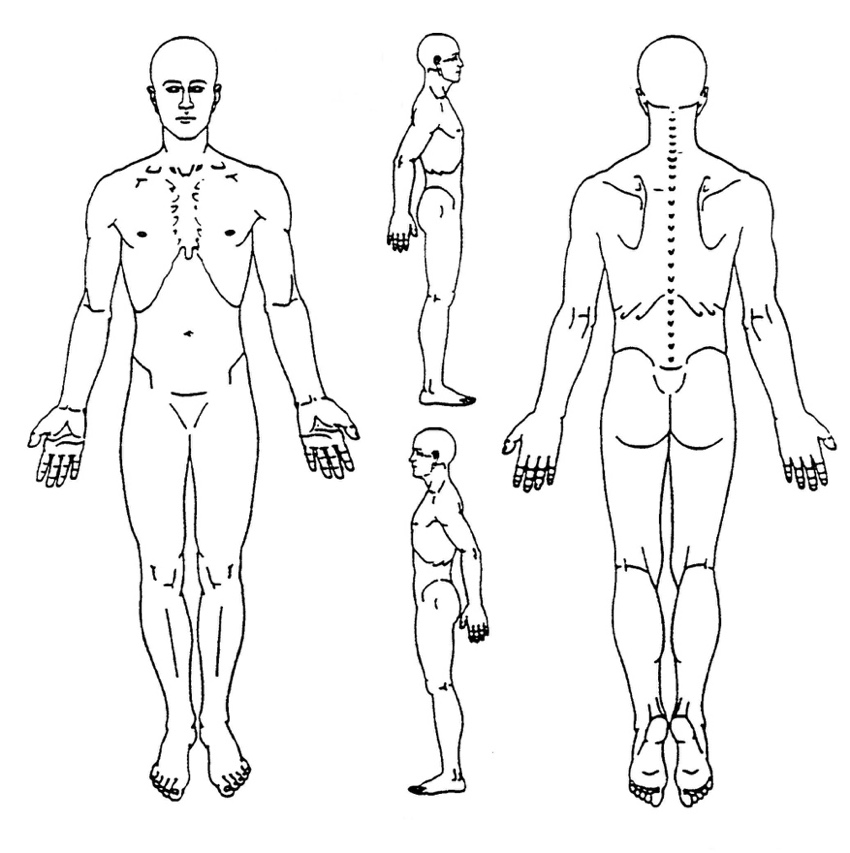
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Do you have any specific body discomfort? If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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?

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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?

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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?

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

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**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.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

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What are your biggest stressors? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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List allergies to medicines, foods and environmental factors:

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

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

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

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**HISTORY**

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

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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:

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List ailments of immediate family and indicate if deceased.

Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else you would like me to know?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Practice and Student Practitioner 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.

**Student Practitioner Information**

The yoga therapy session will be carried out by a student in the advanced level of the Spanda® Yoga Movement Therapist training. The student working with you is not a certified by the International Association of Yoga Therapists, the standard of professional yoga therapy worldwide, and is not yet qualified to offer yoga therapy outside of this practicum experience. However, the student is closely supervised by a yoga therapist who is certified by IAYT. Yoga therapist training, while including some teaching methods, is not a yoga teacher training but a professional level therapist training using the techniques and methods of yoga science and philosophy, many of which have scientific evidence supporting their efficacy. Your case may be discussed during supervision sessions with other trainees with the faculty supervisors while your right to privacy and anonymity will be ensured.

**Practicum Consent**

In consideration of receiving services rendered by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I hereby declare the student has informed be that s/he is in the advanced phase of Spanda® Yoga Movement Therapy training and is receiving supervision of her/his practice sessions. I understand that supervision includes submission of written reports and dialogue with supervisors and other yoga therapist trainees. I have been informed of my right to request the use of my initials or a pseudonym in these interactions and written documents if I choose so. Also, the student has also informed me that s/he is not licensed as a healthcare provider under the laws in this state and is not practicing medicine. S/he will neither diagnose nor prescribe for any concern.

**Waiver**

I hereby release 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.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If under 21, Legal Guardian’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name) (Date)

Legal guardian’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_