Alena Gerst, LMSW, RYT
917-562-2921
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YOGA ASSESSMENT

Name_____ Address_____

Birthdate _____ Tel _____ Email _____

Emergency contact (name, relationship, phone number)

_____

How did you hear about Yogalena Therapeutics?_____

Have you ever practiced Yoga before? If yes, where and for how long?

_____

Have you previously received wellness, complementary, or holistic services? If yes, which services?

_____

HEALTH

How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good Very Good Excellent

What are your health goals?

_____

What are your main physical health concerns?

_____

What do you normally do for exercise?

_____

How would you rate your current emotional/mental health?

Poor Unsatisfactory Satisfactory Good Very Good Excellent

Emotional/mental health concerns

_____

Serious illness, injuries, hospitalizations

_____

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Do you have glaucoma, or history of heart disease or stroke?

_____

Do you experience, or have a history of, chronic pain? If yes, please describe

_____

Please list all allergies

_____

How many hours/night on average do you sleep? _____

How would you rate your sleeping habits/quality of your sleep?

Poor Unsatisfactory Satisfactory Good Very Good Excellent

WORK

What is your occupation?_____

On a scale of 1-10, 1 being very stressful and 10 being excellent, what would you rate your current job?_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

What are some things you do to cope with stress?

_____

What do you consider to be your personal strengths?

_____

PLAN

What do you hope to accomplish with a yoga practice?

_____

Signature_____ Date_____