

Therapeutic Yoga Assessment

Name _____ Address _____

Birthdate _____ Tel _____ Email _____

Emergency contact (name, relationship, phone number)

How did you hear about Alena Gerst Therapy? _____

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

Do you have glaucoma? Y N

Do you have heart disease? Y N

Have you ever had a stroke? Y N

If yes, please explain:

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? Y N

Is there anything stressful about your current work?

STRESS

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 therapeutic yoga practice?

Signature _____

Date _____