**YOGA THERAPY**

**INTAKE FORM**

This information will be kept within Edinburgh Community Yoga and will not be shared beyond our organisation.  We will store this information securely and will delete it after two years if we have not used your information. If you would like us to delete it before the two year mark you are entitled to request that we do so.

I will only use the information provided to design a personalised yoga therapy programme for you and for administrative purposes. All information on this form is strictly confidential and will not be disclosed to anyone unless I am required to do so by law or regulation. In providing the contact details below you consent to my using them should I deem it necessary.

**About You**

|  |  |
| --- | --- |
| **Name** | Click or tap here to enter text. |
| **Date of Birth** | Click or tap to enter a date. |
| **Email** | Click or tap here to enter text. |
| **Mobile** | Click or tap here to enter text. |
| **Occupation** | Click or tap here to enter text. |
| **Name of GP** | Click or tap here to enter text. |
| **Contact Number of GP** | Click or tap here to enter text. |
| **Main contact in Mental Health Team / Psychiatrist** | Click or tap here to enter text. |
| **Contact number for Mental Health Team / Psychiatrist** | Click or tap here to enter text. |

**Your Health**

**Are you currently taking any medication (prescribed by your doctor or bought over the counter, including any herbal or other supplements)?  Yes  No (If yes, please give details)**

Click or tap here to enter text.

**Have you had any major illnesses or accidents?  Yes  No (If yes, please give details)**

Click or tap here to enter text.

**Do you currently have any other physical or mental health problems?  Yes  No (If yes, please give details) Including how this affects you on a day-to-day basis. How long you have been experiencing difficulties. If you have a diagnosis, and if you have had or are currently having any treatment.**

Click or tap here to enter text.

**Have you ever been diagnosed with or suspect you have any of the following?**

**Post-Traumatic Stress Disorder  Addiction issues  Eating Disorder(s)**

**Do you have any low level but regular aches and pains in areas of the body that are troubling you?  Yes  No (If yes, please give details)**

Click or tap here to enter text.

**Do you have any areas where you feel there is a lack of flexibility?  Yes  No (If yes, please give details) Including how long you have experience this. What tends to make the ache/pain better or worse. Indication of what may have caused it and details of any medical treatment received.**

Click or tap here to enter text.

**Have you been to any alternative or complementary practitioners?  Yes  No (If yes, please give details).**

Click or tap here to enter text.

**Do you do any kind of exercise?  Yes  No (If yes, please give details) Including type of exercise and frequency.**

Click or tap here to enter text.

**How often has poor sleep troubled you in the last month?  Always  Very often  Sometimes  Rarely  Never**

**Do you get to sleep easily and rest well through the night?  Yes  No**

**Do you eat regularly with a good appetite?**  **Yes  No**

**Can you go long periods without eating?  Yes  No**

**Does stress affect your eating patterns?  Yes  No**

**How are your energy levels overall? (please give details)**

Click or tap here to enter text.

**Do you notice any changes to your energy levels during the day?**  **Yes  No**

**How are your stress levels currently? (please give details)**

Click or tap here to enter text.

**What are the main sources of stress in your life right now? (please give details)**

Click or tap here to enter text.

**How does stress tend to affect you?  Physical effects in different parts of the body – muscle tension, stomach complaints, headaches  Emotionally – irritable, anxious, angry, lethargic, depressed.**

**What resources help you cope in difficult times?  Internal resources (e.g., self-reliance, determination, self-compassion) or  External ones (e.g., spending time with friends, being outdoors in nature, exercising)?**

**What would you like to gain from yoga therapy? (please give details)**

Click or tap here to enter text.

**What is your main reason for seeking yoga therapy – how do you hope it might help you? (please give details)**

Click or tap here to enter text.

**Do any of the following aspects of yoga interest you?  Building strength  Increasing fitness  Improving flexibility  Pain reduction  Improving posture  Building greater mental and emotional balance  Cultivating spirituality**

Click or tap here to enter text.

**Are there any habits you would like to change? e.g., lifestyle, physical/emotional habits  Yes  No (If yes, please give details)**

Click or tap here to enter text.

**Do you currently have a personal yoga practice or go to regular classes?  Yes  No (If yes, please describe what kind of yoga you do and if/how it helps you)**

Click or tap here to enter text.

**If you have not done yoga before, which type of yoga practice do you feel would be most suited to you? Select one:  Low and Strong  Energetic and Active  Light and Flowing  Don’t Know.**

**Do you have a view as to how often would you like to practice?  Once a week  Three times a week  Weekdays only  Weekends only  Daily  Not sure**

**How much time do you have available in one block for practice?  Two Hours  One Hour  30 Minutes  15 Minutes  5 minutes**

**When do you feel most energetic?  Morning  Daytime  Evening**

**Anything else you think it is important for me to know which is not covered by the questions in this form?**

Click or tap here to enter text.

Click or tap here to enter text.

**SIGNATURE**

Click or tap to enter a date.

**DATE**

Before signing this document, verify that the content you are signing is correct.

Marketing Preferences:

YES I want to receive news from Edinburgh Community Yoga.

NO I don't want to be on the mailing list.