YOGA THERAPY QUESTIONNAIRE This a comprehensive form; a therapeutic yoga practice is designed to address your health on many levels: physical, energetic, mental, and emotional. Do your best to complete the form; please know that strict confidentiality is maintained and your answers are not shared with others.

First Name: _____Last Name: _____
Address: _____ City,
State, Zip: _____ Date of Birth: ___/___/_____
Phone:_____ Email:_____ CWID:_____
Emergency Contact: _____Relationship: _____ Phone: _____

1. What do you hope to get out of your personal Yoga session (mark all that apply):
   ☐ Postural instruction ☐ Stress Relief ☐ Joint Health ☐ Increased Body Awareness ☐ Pain Reduction ☐ Flexibility ☐ Improved sleep ☐ Personalized practice tips
   ☐ Other:_____
2. Please indicate your preferred time to meet:

	Sunday	Monday	Tuesday	Weds.	Thursday	Friday	Sat.
Morning							
Afternoon							
Evening							

HEALTH HISTORY:

Please list your current and previous health conditions.

Please list medical diagnoses, surgeries, accidents, and/or injuries followed by the approximate date:

Are there any other health problems or life challenges that you wish to share?

If your primary reason for the personal session is a health-related, please indicate the current health condition and the length of time you have been dealing with it (e.g. back pain, 1 year; e.g. insomnia, 5 years):

Are you seeing other health professionals for your condition? If so, please describe their discipline and how often you see them (e.g. physical therapist, as needed; chiropractor, weekly)

Please list your current medications, including supplements.

Please state the areas of your body where you are experiencing discomfort. Describe where the discomfort is located and the type and degree of discomfort; level 1 being little pain, and 10 being severe pain (e.g. throbbing knee pain, level 5).

What relieves your pain? What increases your pain? This could be a movement, a yoga posture, or other. (Example: Knee pain increased by descending stairs; decreased when joint is resting).

LIFESTYLE, PERSONAL WELLNESS, AND STRESS:

Describe your lifestyle.

- Do you watch what you eat? ☐Always ☐Sometimes ☐Rarely ☐Never
- How often do you exercise and what kind of exercise do you do? _____
_____

- Do you smoke? ☐Yes ☐No If yes, frequency:_____
- Do you drink? ☐Yes ☐No If yes, frequency:_____

In a few words, describe your typical diet.

In percentages, please indicate how much of your day you are in the following positions:
Sitting: ____% Standing: ____% Lifting: ____% Driving: ____% Computer or desk work: ____% Lying down: ____%

What areas of your life are challenging or stressful? Check all that apply:
☐ Personal ☐ Work ☐ Family ☐ Other

 Date: ___/____/____

What is your CURRENT perceived stress level – low, moderate, or high? □ Low □ Moderate □ High

Do your self-help methods help you deal with stressful situations? □ Yes □ No □ Sometimes

SLEEP, BREATH, & ENERGY:
Describe your sleep habits; for example:

□ Do you get enough sleep? _____
□ How many hours/night do you need to feel refreshed? _____
□ Do you wake up frequently during the night? _____
□ Do you have an established bedtime routine? _____

How would you describe your breathing patterns? Check all that apply:
□ Shallow, chest breathing
□ Deep and rhythmic
□ I don't think about my breath
□ Other: _____

How often do you spend time in nature? Check the statement that applies to you:
□ Every day, I spend some time in nature
□ I get out on the weekends
□ I rarely get out in nature
□ Other: _____

LIFE TOOLS & RESOURCES:

Think about self-healing tools for a moment. This could be a book that you found helpful, a magazine article, a practice, or whatever comes to mind. Then answer the following question: Self-healing practices have worked in the past (check all that apply):
□ Yes □ No □ Sometimes □ Rarely □ Never

Are there currently aspects of your life that give you joy and pleasure?
□ Yes □ No □ Sometimes □ Rarely □ Never

Do you have a creative outlet (e.g. singing, journaling, writing, dancing, art, gardening, creative projects, etc.?) □ Yes □ No □ Sometimes □ Rarely □ Never

Do any of the following statements apply to you (please mark the ones that apply):
□ I believe that most of life's daily challenges can be overcome
□ I believe that life is hard and survival is a struggle
□ I'm just waiting for the next big issue to come up and wear me down
□ IN YOUR OWN WORDS, I believe: _____

Are you conscious of a higher purpose or meaning of your life?
□ Yes □ No □ Sometimes □ Rarely □ Never

If you could change just one of your habits, what would that be?

YOGA HISTORY (PLEASE COMPLETE IF YOU HAVE EXPERIENCE WITH YOGA)

- What is your experience with Yoga, meditation or other spiritual practices?

- How often do you practice and is your practice regular?

- Do you experience pain or discomfort in any pose? Which one/s?

- Where is the pain and when do you feel it?

- Have you had any previous Yoga injuries? How did they happen?

RELEASE AND INDEMNITY AGREEMENT: I hereby release Michelle Labbe and Yoga With ShaSha from all claims that may be sustained while attending this session, and I agree to indemnify Michelle Labbe and Yoga With ShaSha for any claim which may hereafter be presented as a result of such injuries. Print Name _____
Signature _____
Date_____

Please return form to: Michelle Labbe
Email: OmSoGlamorous@aol.com
Phone or text message: (703)405-8787