Embody Balance
THERAPEUTIC YOGA AND MASSAGE

Information Sheet

(Please note that all information will be kept confidential)

Name ____ Date_____________

Address____

Home Phone ____________________________ Cell Phone _____________________

Email____

Preferred method of communication ______ Email ______ Phone

Gender _____ M ______ F Age _________ Marital Status: _______________

Occupation____

Chief Concern ____

____

Goal(s) for Yoga Training ____

____

____

Yoga History: ____ Yes _____ No

If yes, Style_____________ Frequency_______________

Length of Practice_________ # of years________

Meditation Practice: _____ Yes ______ No

If yes, Frequency _____________ Length of practice: __________ # of Years: ________

Embody Balance

THERAPEUTIC YOGA AND MASSAGE

How much time per day are you willing to commit for yoga practice?

____

Medications: (Prescription, OTC, Naturopathic, Complementary & Alternative)

____

____

____

Use of Alcohol/Recreational Drugs ___ Never _____ times a week OR
_____ times a month

Smoking Never _____ Cigarettes a day OR ____ Packs a day # of years ______

Other relevant health history you would like to share: