Private Lessons with TINA LOREN YOGA

Welcome

WWW.TINALOREN.COM

NEW CLIENT INFORMATION

Information

Name: _____Nickname, if preferred: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email address: _____

Phone #s: Cell _____ Home _____ Work _____Ext:_____

Preferred method for appt reminders? [ ] Email [ ] Cell [ ] Home [ ] Work

Birthday (mm/dd/yy): ___/____/___ Current Occupation: _____ [ ] Full-time [ ] Part-time

Emergency Contact: Name: _____ Relationship _____ Phone #:_____

Policies

I agree to give 24 hours notice for any cancellations or modifications to my scheduled appointment or I will be charged in full. I understand the each session is 60-75 minutes, time will not be added to my appointment for my tardy arrival and I will be charged in full for my scheduled session. I understand that packages expire 6 calendar months from purchase and are non-transferable and non-refundable. I have read and signed the Release/Wavier of Liability and completed the client information form prior to scheduling. INITIAL HERE: _____

Session Comfort

Do you tend to run: warm / cold / neither (Please be prepared by wearing comfortable layers)

Please circle any that will make your experience more pleasant and cross out any that will adversely affect your session: candlelight / incense / sage / light music / other: _____

Do you have any pet/animal or other environmental allergies? _____

Goals

Are you interested in: [ ] Yoga Therapy [ ] Private Yoga Sessions [ ] Meditation

What would you like to achieve out of our sessions together?

_____

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Health History

Age_____ Height_____ Weight_____

Please list your yoga experience, if any. _____

Rate your Digestion: Poor_____ Fair_____ Good _____ Excellent _____

Rate your Breathing: Poor_____ Fair_____ Good _____Excellent _____

Are you a nose or mouth breather? _____ Asthma: Yes / No

High/Low blood pressure? Yes / No Is it controlled with medication? Yes / No

History of heart disease? Yes / No History of drug abuse? Yes / No

History of anxiety or depression medication? No / Yes How long? _____

Current perceived stress level: [ ] high [ ] moderate [ ] low

How many hours of sleep do you average? _____ Do you have any difficulty sleeping? No / Yes

Indicate Your Frequency of the following using a scale of [Rarely, Sometimes, Often, Most of Day]

Driving _____Sitting_____Standing_____Computer_____Carry weight_____

How many times per day do you eat and what are the sizes of your meals?_____

Describe your weekly diet in terms of meat, dairy, fruits, vegetables, grains, water, tea, coffee, energy drinks, sodas, etc. _____

Are you currently taking any medication? [ ] No [ ] Yes List: _____

Do you have a health condition or are you on any medication that would preclude you from practicing yoga? No / Yes List: _____

Women: Are you pregnant or is there any current possibility of being pregnant? [ ] No [ ] Yes

List any surgery(s), accidents, diseases, other relevant conditions and their beginning and end date(s).

_____

Current health concerns you would like to focus on? No / Yes List: _____

Who may I thank for your referral?

REFERRAL: Healing Practitioner / Another Client / Friend Name:_____

INTERNET: Facebook / Twitter / Yelp / Google Search, keywords:_____

ADVERTISING: Flyer / Business Card / Other:_____

Add me to your newsletter to receive information on upcoming events and discounts. Yes / No