



## YOGA INTAKE

**Welcome! Thank you for choosing Ripple for your health care needs. We are here to help and are excited to share our passion for healing.**

Thank you for taking the time to fill out these forms. This information gives us a comprehensive picture of your health status and improves our ability to address your health concerns.

<b>Date:</b>	<b>Name:</b>	<b>Date of Birth:</b>
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Is there a primary issue you would like to address with yoga today and at future visits?

Is there a secondary issue you would like to address with yoga?

Have you received a diagnosis for a condition you want to address?

Have you received previous treatment for a condition you want to address?

What seems to help the condition the most?

What seems to aggravate the condition?

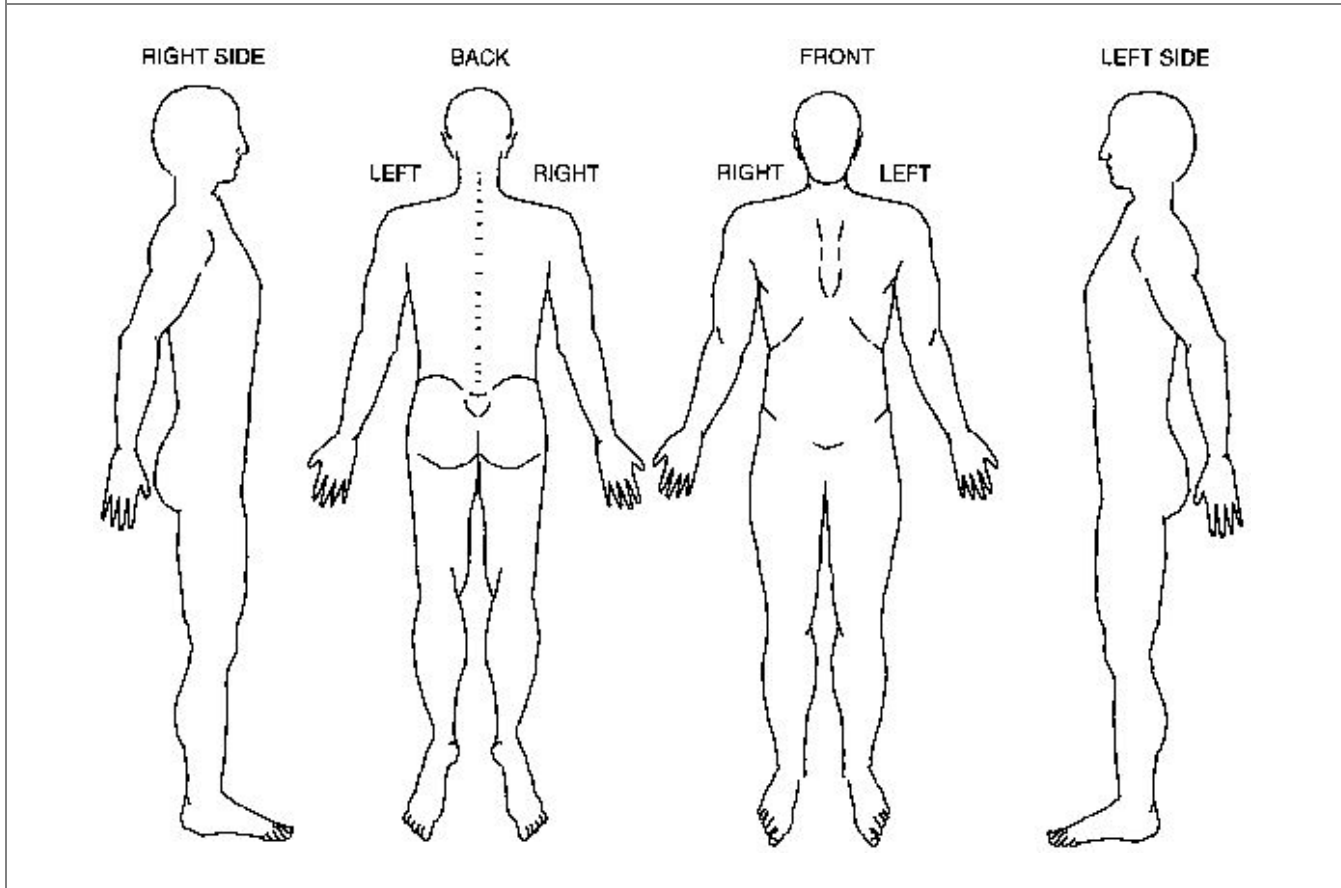
Do you have any chronic or recurring health issues?

List any physical activities you do regularly (sports, strenuous tasks, etc)

**Please indicate if any of the following apply to you:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Back/Neck Pain Issues | <input type="checkbox"/> Numbness/Tingling  | <input type="checkbox"/> Addictive Issues<br>(Alcohol, Drugs, Food, Etc.) |
| <input type="checkbox"/> Stroke                | <input type="checkbox"/> Broken Bones/Dislocations                                | <b>WOMEN</b>  |
| <input type="checkbox"/> Blood Clots           | <input type="checkbox"/> Contagious Skin Disorder<br>(Warts, Athletes Foot, Etc.) | <input type="checkbox"/> Pregnant   |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Bruise Easily  | <input type="checkbox"/> Painful Menstruation                             |
| <input type="checkbox"/> Scoliosis             | <input type="checkbox"/> High Blood Pressure                                      | <b>OTHER</b>  |
| <input type="checkbox"/> JM/Jaw Pain           | <input type="checkbox"/> Cancer   | HIV/AIDS, Fibromyalgia,<br>Chronic Fatigue, Lupus, Etc.                   |
| <input type="checkbox"/> Recent Surgery        | <input type="checkbox"/> Headache   | Please<br>Describe _____  |
| <input type="checkbox"/> Whiplash              |   |   |

**If there is physical pain or disability associated with this condition, please mark where it affects below:**



**Thank you for taking the time to fill out this waiver and consent form, I look forward to working with you.**

I, \_\_\_\_\_ (**print name**), understand that yoga includes physical movements. As is the case with any physical activity, the risk of injury, even serious or disabling, is always present and cannot be entirely eliminated. Yoga is not a substitute for medical attention, examination, diagnosis or treatment. Yoga is not recommended and is not safe under certain medical conditions.

I affirm that I alone am responsible to decide whether to practice yoga. I hereby agree to irrevocably release and waive any claims that I have now or hereafter may have against Ripple and its instructors.

**I have read and understand the above statements.**

**Responsible Party Signature**

**Date**