

**Yoga Therapy for Shoulders, Low Back, and Hips**

Dear Clinical Yoga Therapy Case Study Applicant,

Many thanks for your interest in our program. We will do our best to secure a spot for you in our on-going free Saturday Clinic. Our only request is your commitment to at least four (4) sessions so that our Clinical Therapy candidates may monitor and learn from your progress. Each session will provide you with a comprehensive Yoga Therapy Protocol along with picture tutorial taken during your session so that you might practice at home.

To apply, please fill out the attached Clinical Case Study Application, read and sign the attached Disclosure and Photo Release forms, and return to my attention at:

AUM Home Shala  
Attn: Melinda Atkins, Director

3104 Florida Ave.  
Coconut Grove, FL 33133

Should you have any questions, feel free to contact us via email (info@aumhomeshala.org) or phone (305-441-9441) .

Namaste,

Melinda Atkins

Director

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**Clinical Yoga Therapy Case Study Application**

**Confidential Health Background**

**Personal Information**

**Name:** ­­­­­­­­­­­­ **Birthday:**

**Daytime Phone:** **Evening Phone:**

**Email Address:**

**Occupation:**

**Address:** **City:** **State:** **Zip:**

**Emergency Contact:** **Phone:**

**The following confidential information will** b**e used to plan safe and effective yoga therapy sessions. Please answer the questions to the** b**est of your knowledge.**

**Reaso**n **for your visit:**

**What is your primary issue?**

**How often do you experience your symptoms?**

Constantly (76-100% of the time); Frequently (50-75%)

Occasionally (26-50%); Intermittently (up to 25%)

**When did you first notice it?**

**What activities provide relief?**

**What makes it worse?**

**How are your symptoms changing with time?** (circle one)

Getting Worse Staying the same Getting better

**Have you tried ay other therapies or treatments?** *(Y/N)*

*If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Describe your sleep recently:**

**What do you hope to accomplish?**

\_\_\_ Body Awareness

\_\_\_ Muscle Strengthening \_\_\_ Muscle Stretching and Flexibility

\_\_\_ Improve Other Body Systems: \_\_\_ Stabilization of Joints

\_\_\_ Diet and Lifestyle \_\_\_ Pain Reduction

\_\_\_ Digestion and Elimination \_\_\_ Overall Posture Improvement

\_\_\_ Specific Yoga Postures or Practices \_\_\_ Improve Breathing

\_\_\_ Improve Energy Level \_\_\_ Improve Sleep

\_\_\_ Breath Awareness \_\_\_ Overall Stress Reduction

\_\_\_ Less Trouble Handling Emotions \_\_\_ Less Reactive/Upsetting

\_\_\_ Less Anxiety or Depression \_\_\_ More Satisfying Personal Relationships

\_\_\_ Finding Greater Fulfillment at Work \_\_\_ Greater Sense of Self-esteem

\_\_\_ Other goals:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How much time per day can you devote to doing yoga or healing work?**

**Health History**

**Are you currently under a physician’s care for an acute or chronic issue?** *(Y/N)*

*If yes, please explain* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last Physical Exam: \_\_\_\_\_\_\_\_\_

**What do you do for relaxation/exercise?**

**Do you exercise regularly and/or participate in any sport?** *(Y/N)*

***If yes, which sport*?**

**Have you recently suffered an injury?** *(Y/N)*

***If yes, please explain***

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Are you *uncomfortable* with any of the following areas:**

*Gluteal Region (Y/N) Pectoral Region (Y/N) Face/Scalp (Y/N) Feet (Y/N)*

**Please list any medications (vitamins, herbs or pharmaceutical) you are currently taking or at regular intervals?**

**Please list any injuries/accidents/illnesses or surgeries still affecting you and how you have been caring for them:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you experience stress in your work, family or other aspects of your life?**

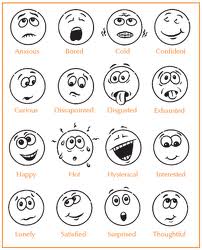
(Circle the one that best describes)



**And how you believe it affects your health:**

Muscle tension Anxiety Insomnia Irritability Digestive Disturbances

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle the face or faces that best describes how you are feeling 

**Using the symbols below, please identify the areas of concern on the chart below:**

**/// (sharp pain) xxx (burning , radiating pain) ~~~~ (numbness) 000 (dull ache)**



**Health History**

*Please indicate any Present (P), Past (X), or Reoccurring (C) conditions:*

\_\_\_\_ ADD/ADHD \_\_\_\_Metal implants / artificial joints

\_\_\_\_ Allergies \_\_\_\_ Mononucleosis

\_\_\_\_ Alzheimer’s disease \_\_\_\_ Multiple Sclerosis

\_\_\_\_ Anxiety disorder what stage? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Arthritis \_\_\_\_ Muscular Dystrophy

\_\_\_\_ Athletes foot \_\_\_\_ Numbness/ Tingling

\_\_\_\_ Asthma \_\_\_\_ Osteoporosis/Osteopenia

\_\_\_\_ Blood Clot/ Deep Vein Thrombosis/ \_\_\_\_Osteoarthritis

Phlebitis/ Embolism \_\_\_\_ Pain

\_\_\_\_ Broken or fractured bones \_\_\_\_ Rheumatoid Arthritis \_\_\_\_ Bursitis -Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Cancer --Muscular or Joint: \_\_\_\_\_\_\_\_\_\_\_\_\_

--Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ -- Chronic? Y/N

--Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Paralysis

-- In Remission? Y/N \_\_\_\_ Parkinson’s disease

\_\_\_\_ Carpal Tunnel Syndrome \_\_\_\_ Pregnancy

\_\_\_\_ Cerebral Palsy \_\_\_\_ Psoriasis

\_\_\_\_ Chronic Fatigue Syndrome \_\_\_\_ Rash

\_\_\_\_ Contagious condition \_\_\_\_ Sciatica

\_\_\_\_ Crohn’s disease \_\_\_\_ Scoliosis

\_\_\_\_ Depression \_\_\_\_ Seizure

\_\_\_\_ Diabetes \_\_\_\_ Sleeping problems

\_\_\_\_ Type I \_\_\_\_ Type II \_\_\_\_ Spasms/ Cramping

\_\_\_\_ Diverticulitis \_\_\_\_ Strain/ Sprain

\_\_\_\_ Eczema \_\_\_\_ Stroke

\_\_\_\_ Epilepsy \_\_\_\_ Tendonitis

\_\_\_\_ Epstein Barr \_\_\_\_ Thyroid issues

\_\_\_\_ Fertility Concerns \_\_\_\_\_TMJ/ Jaw Pain

\_\_\_\_ Fibromyalgia \_\_\_\_ Tumor

\_\_\_\_ General Fatigue Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Gout Malignant or Benign? \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Headaches \_\_\_\_ Varicose Veins

Type: \_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Vertigo, dizziness or loss of balance

\_\_\_\_ Hearing Impairment \_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Heart Condition

\_\_\_\_ Herpes/ Shingles

\_\_\_\_ High/ Low Blood Pressure

\_\_\_\_ High/ Low Cholesterol

\_\_\_\_ HIV/AIDS

\_\_\_\_ Lupus

\_\_\_\_ Lymph edema

**Disclosure Statement**

In consideration of AUM Home Shala, Inc. and/or Melinda Atkins extending to me the privilege of participating in their Yoga & Therapies program, I fully assume all risks and waive all liability in connection with my participation in any program, and in particular, without limitation, to the extent permitted by law, I and my heirs, representatives, executors, or administrators and my undersigned parent, guardian or aide (if applicable) remise, release, indemnify, acquit and hold harmless and forever discharge AUM Home Shala, Inc. and/or Melinda Atkins , their directors, employees, and agents, instructors, including volunteers, rescue and support personnel, from any and all liabilities, obligations, damages, claims, causes of action, judgments, costs and charges which I may have or which may be incurred by me for any reason of any occurrence during my travel to and from the event, or during my participation therein, whether resulting from any acts or omissions of any persons, from the operation or condition of facilities or premises, or from acts of God or nature. I hereby agree to comply with all rules and regulations, give my permission for the free use of my name and picture in any media account of the AUM Home Shala, Inc. and/or Melinda Atkins, Yoga & Therapies programs or any future public relations or fundraising activity. I also agree to assume liability for all and any damages to AUM Home Shala, Inc. and/or Melinda Atkins, property that is under my control while participating in any AUM Home Shala, Inc. and/or Melinda Atkins, Inc activity. Not all techniques are suitable for everyone. Participation in any treatment/exercise program may result in injury. By doing the movements, exercises, you assume the risk of injury from performing the movements and techniques shown. Consult your physician before doing any exercises, especially if you suffer from an injury or medical condition.

\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Name (please print) Student Contact #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Name (please sign)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name & Phone #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address

Mailing Address:

**Release and Consent to Video or Photograph**

For use to promote AUM Home Shala Yoga Programs

Subject’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(PLEASE PRINT)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Numbers: (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Cell)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUM hOMe Shala established its Clinical Yoga Therapy Program in 2011 to promote the use of Yoga Therapy as an integrative, alternative, and complementary form of health care. I understand that AUM hOMe Shala routinely promotes the educational, heath, and spiritual benefits of Yoga Therapy in rehabilitation. I also understand that AUM hOMe Shala creates teacher manuals and videos of technique to share with others.

I hereby consent to being the subject of photographs and videos taken for the above stated purposes and promoting Shala Yoga programs and hereby release AUM hOMe Shala from any and all claims for damages for libel, slander, invasion of privacy, or any other claim based upon the use of my image and likeness as stated above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name