**AUM hOMe Shala Yoga**

** Adolescent In-Take Form**

**Confidential Health Background**

**Personal Information**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday: \_\_\_\_\_\_\_\_\_\_\_\_

Sex: \_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_

Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_

Daytime Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evening Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Student Presently Attends: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_

School(s) Student has Previously Attended (include Grades completed and years spent at each school):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Programs (Gifted, Special Needs, etc)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Extracurricular Activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? Referred by?

**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? (circle one)

Constantly (76-100% of the time) Frequently (50-75%) Occasionally (26-50%) Intermittently (up to 25%)

When did you first notice it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you know what brought it on? \_\_\_\_\_\_\_\_\_

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 any other therapies or treatments? *(Y/N) If yes, please describe:*

Describe your sleep (times for sleep, deep sleep, restless sleep, how many hours/day):

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 school, 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

\_\_\_\_ Hearing Impairment balance

\_\_\_\_ Heart Condition \_\_\_\_\_Menstruation

\_\_\_\_ Herpes/ Shingles \_\_\_\_\_ PMS/Symptoms\_\_\_\_\_\_\_

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

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

\_\_\_\_ HIV/AIDS Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Lupus

\_\_\_\_ Lymph edema \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**AUM hOMe Shala** **Professional Disclosure Form and General Release**

We are delighted to have you as a Yoga student. The following information will help you get the most out of your Yoga classes and clarify the role of a Yoga teacher. Please read and sign below.

1. I am a Yoga Teacher at AUM hOMe Shala and have completed a thorough professional training in Yoga instruction. I have a Yoga Certification and am registered with the Yoga Alliance. Yoga is much more than physical exercise; it is a transformational practice that integrates body, mind and spirit. Yoga is a way of encountering and releasing physical, mental, and emotional tensions to arrive at deeper levels of relaxation and awareness.
2. All exercise programs involve a risk of injury. By choosing to participate in my

Yoga classes, or any other classes at AUM hOMe Shala, you voluntarily assume a certain risk of injury. The following guidelines will help you reduce your risk of injury:

* Listen to and follow Yoga Teacher’s instructions carefully.
* Breathe smoothly and continuously as you move and stretch.
* Do not hold your breath or strain to attain any position.
* Work gently, respecting your body’s abilities and limits.
* Don’t perform postures or movements that are painful.
* Ask if you are unsure how to perform a certain movement.
* Menstruating women should not practice inverted postures.
* Pregnant women must consult their health care provider before enrolling in class.

 3. It is always advisable to consult your physician before embarking on any exercise

 program. Please complete the Student Health Questionnaire Form and inform the

 teacher of any health conditions that could be affected by your practice of Yoga.

 If you are unsure about a condition, please speak to your teacher.

1. Awareness is fundamental to the practice of Yoga. It is your responsibility as a

 student to monitor each activity and determine whether it is appropriate for you to

 participate. Though I am your teacher, you remain primarily responsible for your

 safety and well-being.

The undersigned assumes all risk of damage or injury that may occur as a student in AUM Home Shala Yoga classes, both while attending classes and following instruction at home. In consideration of being accepted as a Yoga student the undersigned releases and discharges Melinda Atkins and AUM hOMe Shala and teachers from any and all claims, demands, actions of any nature, whether present or future, anticipated or unanticipated, known or unknown, that result from the undersigned’s participation in Yoga classes or practice of Yoga outside of class.

I have read, understand, and agree to the content of the Professional Disclosure Form and General Release.

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

Signature (Parent or Guardian) Date

Print Name Teacher’s Name



**Release and Consent to Photograph**

For use to create AUM Home Shala Yoga Protocols for Student Use

Student’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(PLEASE PRINT)

Parent’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(PLEASE PRINT)

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

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

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

AUM Home Shala established its Yoga Teachers Training Program in 2005. I understand that AUM hOMe routinely promotes the educational and health benefits of participating in the activities of on going Yoga classes and training programs.

I hereby consent to my child being the subject of photographs taken to create AUM Home Shala Yoga protocols for educational use by the student and hereby release AUM hOMe 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.

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

Parent Signature (if student is under 18) Date

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

Melinda Atkins, M.ED., E-RYT500C Date

Director