



Client-Confidential

WHAT IS "YOGA AS THERAPY"?

The term yoga comes from a Sanskrit word, which means yoke or union. On a physical level, yoga postures, called asanas, are designed to tone, strengthen, and align the body. These postures are performed to make the spine supple and healthy and to promote blood flow to all body systems, organs, glands and tissues. On the mental level, yoga uses breathing techniques (pranayama) and meditation (dyana) to quiet, clarify and discipline the mind.

Specifically, yoga therapy is a type of therapy that uses yoga postures, breathing exercises, meditation, and guided imagery to improve mental and physical health. The holistic focus of yoga therapy encourages the integration of mind, body, and spirit.

Yoga can increase general health & stamina, reducing stress and improving those conditions brought about by a sedentary lifestyle or injury. Yoga has the added advantage of being a low-impact activity that uses only gravity as resistance, which makes it an excellent physical (yoga) therapy routine while certain yoga postures can be safely used to strengthen and balance all parts of the body.

Yoga practice contains the central idea that physical posture and alignment can influence a person's mood and self-esteem, and also that the mind can be used to shape and heal the body.

WHY WORK WITH TEACHERS AT HEALTHY LIVING MOXIE?

Teachers at Healthy Living Moxie are certified by the International Association of Yoga Therapist with their C-IAYT certification and have a minimum of 500-hour training in yoga as therapy. At Healthy Living Moxie, we also incorporate the BEMER with our private yoga therapy sessions. Each session begins with centering on the BEMER, which is a therapeutic modality that facilitates functional blood flow within the body. It does so by generating a biorhythmically defined energy signal which targets both systemic and local circulation systems within the body. It's simply a mat you lie on for 8 minutes to increase the blood flow throughout the body increasing oxygen & nutrient delivery and removal of toxins at a cellular level. The individual applications will be used as needed based on the client's individual needs.

YOUR FULL ENGAGEMENT IS NECESSARY!

The purpose of individualized sessions with yoga therapy is to teach the client how to continue the practice outside of the session and learn techniques for self-care. If the work is only done during the sessions with the yoga therapy teacher, and not done by the student between sessions, progress in addressing the issue will be limited, or worst yet, not occur at all. Please make a commitment to yourself to spend 30 minutes to one hour every day while you're in the program to achieve your desired result(s).



INTAKE FORM

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Client Name: _____ Date of intake: __/__/__

Cell Phone: (____) _____ Email: _____

Home Phone: (____) _____

Best way to reach you: Email: Text: Cell Phone: Home Phone:

Referred by: _____

Your Home Address: _____

Sex: M F Date of Birth __/__/__ Height ____ - ____ Weight: _____ lbs.

Emergency Contact: _____ Relationship: _____

Phone Number: (____) _____

Address: Same Other: _____

Occupation: _____

Would you say you: Enjoy work Tolerate work Dislike work

Are you pregnant? YES NO

Are you taking blood thinners? YES NO What brand: _____

Have you had an aneurism in the last 12 months? YES NO When: _____

Have you ever had an organ transplant? YES NO If yes, when? _____

How would you rank your overall health: 1 2 3 4 5 6 7 8 9 10

Please provide a brief description why: _____

Please provide a brief description what you have done to resolve these issues: _____



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What is your reason for seeking yoga therapy?

Are your daily activities limited by your current condition? YES NO Please explain:

What specific results do you hope to obtain from your yoga therapy sessions (with respect to your body, life, activities, etc.)?

What are you currently doing for yourself to obtain these goals?

Exercise – type(s): _____ How often? _____

Massage – type(s): _____ How often? _____

Sports Activities – type(s) _____ How often? _____

Outdoor Activities – type(s) _____ How often? _____

Medical Therapy – type(s) _____ How often? _____

Other – type(s) _____ How often? _____

Please circle the kinds of manual therapy and exercise therapy you have experienced before:

General Massage	Sports Massage	Structural Massage	Rolfing	Hellerwork	Lymphatic Massage
Chiropractor	Physical Therapy	Manual Physiotherapy	Yoga Therapy	Cranial Sacral	

Has your experience with these therapies been positive? Please explain if negative:



Medical Review and History (Please circle all that apply):

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(This information is gathered to evaluate potential contraindications to manual and yoga therapy, limitations or precautions. All information provided will be held in compliance with HIPPA Laws & Guidelines).

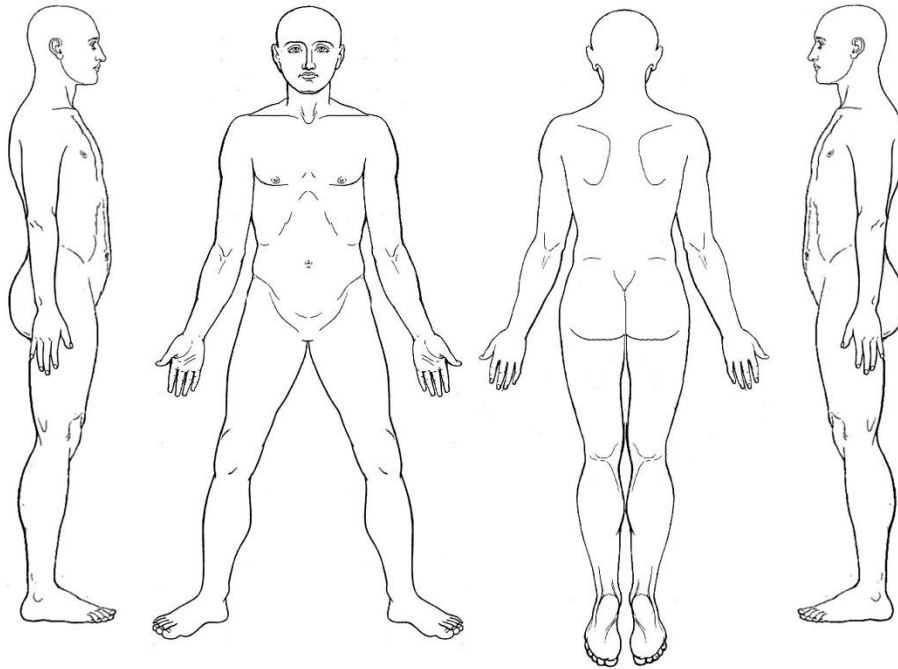
On your body:	Joints or Pain:	Illnesses or Disease:
Wear contact lenses	Migraine headaches	Diabetes
Dentures	Headaches in general	Diabetic ulcers
Hearing aid	TMJ (jaw) pain	High blood pressure
Pacemaker	Neck joint pain or problems	Cardiac problems
Chemotherapy port	Shoulder joint pain or problems	Phlebitis (blood clots in leg)
OTHER:	Elbow joint pain or problems	Vascular constriction (cold)feet
	Wrist joint pain or problems	Vascular constriction (cold) hands
SKIN:	Back pain, stress or problems	Numbness or tingling anywhere
Herpes (oral cold sores-Type I)	Sciatic (hip or leg pain)	Breathing problems
Herpes (genital- Type II)	Knee joint pain or problems	Sinus congestion or infection
Skin infection (currently)	Ankle joint pain or problems	Allergies
Psoriasis or eczema	Foot joint pain or problems	Digestion or GI problems
Bruise easily	Muscle spasms	Stomach Ulcers
Significant warts or growths	Artificial joints	Passing stones gall bladder
Corns or bunions	OTHER:	Passing stone kidney
Skin cancer		Epilepsy
Significant scars		Cancer (_____)
		Cancer treatment: chemo() radiation ()
Sexual Abuse:	Pregnancy & Births:	Mastectomy: right () left ()
Victim of sexual abuse	Currently pregnant	Neurological: (_____)
	Currently nursing	Drug or alcohol problems
Environmental and lifestyle:	Natural childbirths (# _____)	Car accidents/whiplash (list dates in notes)
How often exercise each week (_____)	C-Section childbirths(# _____)	Illness: current () recent ()
Fitness ability? Good () Average ()	Delivery complications	Therapy/counseling: current () past ()
Poor (_____)	Miscarriages	Smoker: current () past () date quit:
Number of hours sleep each night (_____)		Weekly alcohol consumption:
Briefly describe your diet:		

Additional notes and details of injuries:

Medications (Please list important pharmaceutical medications and regular OTC medications you are taking):

(Female clients, please inform practitioner each session if you are in your menstrual cycle, as this may affect your treatment plan for that session. Thank you)

Please note areas of concern with arrow and brief description:



Please list all major surgeries, fractures, injuries and when they occurred:

	Description	When
Major Surgeries		
Broken Bones		
Injuries		

Notes: Please list what your greatest concern is:

Client Name: _____ Date: _____



Consent for Yoga Therapy & BEMER Session

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I hereby apply for and consent to yoga therapy from Healthy Living Moxie, LLC, a practitioner of Healthy Living Moxie. The practitioner has explained to me the general process and theory behind yoga therapy and the various results that may be expected from movement education. I understand these results vary from individual to individual and that no specific results can be guaranteed.

Furthermore, I understand that any relief of physical or emotional symptoms is coincident with the alignment and organization of the total human being, and that alleviation of symptoms is *not* the primary goal of yoga therapy, rather a holistic approach to healing and self-care.

I understand that the Practitioner does not treat, prescribe for, or diagnose any illness, disease, or any other physical or mental disorder, injury, or condition. Nothing said or done by the Practitioner should be construed as such. I further understand that the Practitioner is not attempting to practice medicine, osteopathy, chiropractic care, physical therapy, psychology, or any profession requiring a license under the laws of any state.

I understand that it is necessary for the Practitioner to assist my body in order to assist me in establishing balance and alignment in my body. I give the Practitioner my permission and consent necessary to do all those things necessary in helping me establish balance and alignment. I give the Practitioner full privilege and license to work with my body in such a way as to restore and establish balance and alignment therein. **I have been informed by the Practitioner that at any time, I may ask to stop the exercise for any reason whatsoever, and that the Practitioner will immediately comply with my request.** Furthermore, it is understood that the Practitioner will respect my personal comfort level and boundaries with degree of how much and how long exercise/practice I can endure.

I understand that my treatment records may be used by the Practitioner to consult with other Yoga Therapy Practitioners in the course of my treatment.

When using the BEMER, I understand it is in no way a substitute for medical care. There are no medical claims being made from the use of the BEMER. I understand statements made have not been evaluated by the FDA; however, BEMER products are FDA registered Class I medical devices. By signing below I am stating that I am in agreement and waive and release all liability as outlined for the BEMER Group or individuals conducting the session from responsibility for any injury.

I, undersigned, agree that yoga therapy conducted by Healthy Living Moxie, LLC is not physical therapy. I agree that all sessions shall be undertaken by me at my sole risk and that Healthy Living Moxie, and their Practitioners shall not be liable to me for any claims, demands, injuries, damages, actions or course of action whatsoever to my person or property arising out of or connected with the use of the services and facilities of Healthy Living Moxie, LLC. I do hereby forever release and discharge Healthy Living Moxie, LLC and their Practitioners from all claims, demands, injuries, damages, actions or course of action, and from all acts of active or passive negligence on the part of Healthy Living Moxie, LLC.

By signing this form, my consent applies to this session and all subsequent sessions by the Practitioner. I agree to give my Practitioner at least 24 hours' notice of cancellation of an appointment. I fully understand that I will be charged the full hourly rate for my appointment if I fail to provide 24 hours' notice. By signing the consent agreement, I am personally fully accountable and responsible for all services provided to me by the Practitioner. Payment is expected at the time of service.

DATE: _____ CLIENT NAME (PLEASE PRINT): _____

SIGNATURE: _____

PARENTS NAME/SIGNATURE (if client is a minor): _____