Corewell Health™

Yoga Therapy New Patient Intake Form

Name: _____ **Date of Birth:** _____ **MRN:** _____

How would you like to be addressed? _____

Preferred Pronoun? _____

Email Address: _____

Would you like to be added to Integrative Medicine's electronic newsletter email list? Yes: ☐ No: ☐

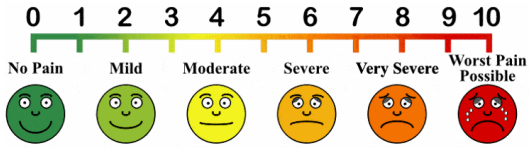
List your health goals and what you would like to achieve through yoga therapy:

Priority 1: _____ Priority 3: _____

Priority 2: _____ Priority 4: _____

Describe your current pain:

Circle your pain level on the scale.



Indicate any area of your body where you experience pain, tension, or stress:

What Decreases Your Pain

_____

_____

_____

_____

_____

_____

What Increases Your Pain

_____

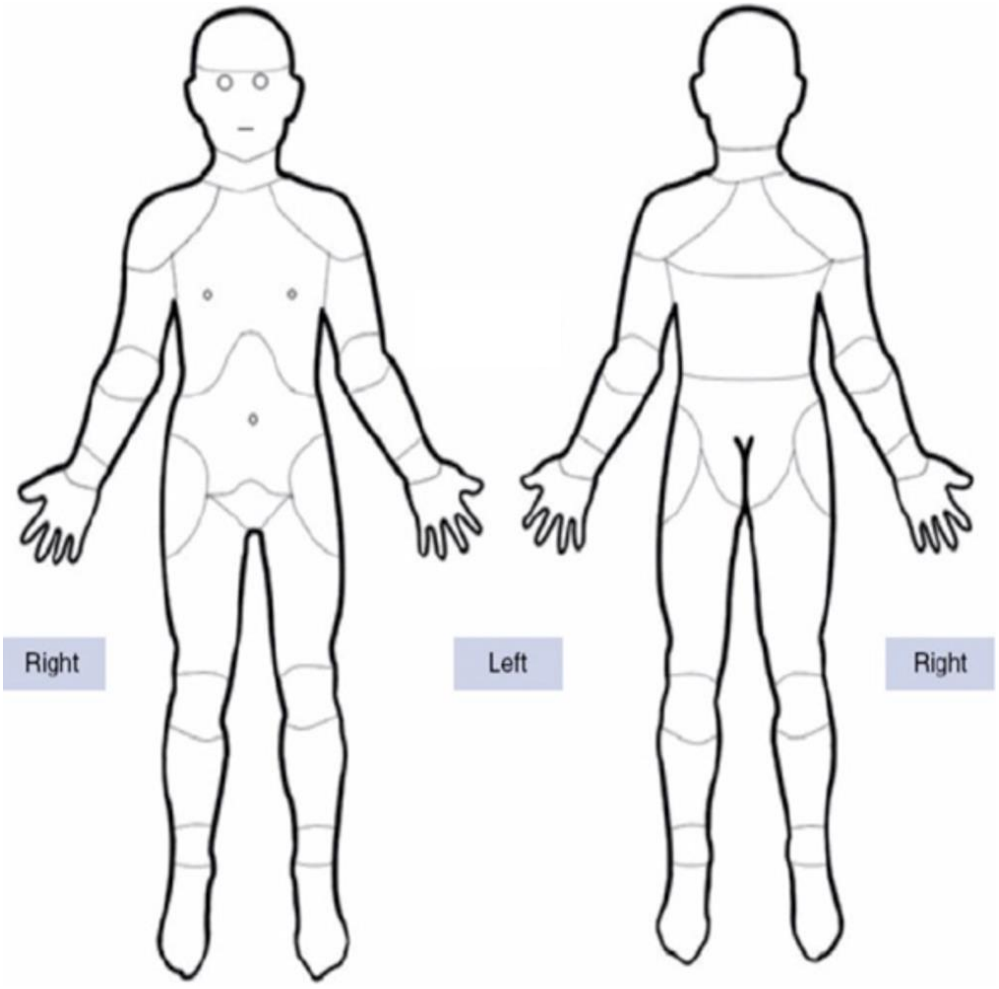
_____

_____

_____

_____

_____



MRN: _____

Current Stress Level

Circle Your Stress Level on the Scale Below

What causes you stress? _____

How do you manage stress? _____

Current Energy Level

Circle Your Energy Level on Scale Below

How does your energy level change throughout the day? _____

Sleep

Number of hours per night? _____ During the night, how often do you wake up? _____

Refreshed upon waking? Yes: ☐ No: ☐

Exercise

Do you exercise regularly? Yes: ☐ No: ☐

Type of exercise: _____ Frequency: _____

Type of exercise: _____ Frequency: _____

Digestion/Nutrition

How often do you eat? _____ What snack food do you enjoy? _____

Do you have any food intolerance? Yes: ☐ No: ☐ Describe: _____

Describe your appetite: Always Hungry Regular Rarely Hungry

Do you have any discomfort after a meal? _____

Do you have any concern about the regularity of your bowel movements? _____

How much water do you drink per day? _____ How much caffeine do you consume per day? _____

MRN: _____

Medical History

Surgeries Location: _____ When: _____

Location: _____ When: _____

Injuries Location: _____ When: _____

Location: _____ When: _____

Use the back of this page if more room is needed: ☐

Health Conditions

Do you have or have you had (please explain any Yes responses)?

Cardiovascular Disease:	Yes: ☐	No: ☐	_____
Hypertension:	Yes: ☐	No: ☐	_____
Cancer:	Yes: ☐	No: ☐	_____
Diabetes:	Yes: ☐	No: ☐	_____
Thyroid Dysfunctions:	Yes: ☐	No: ☐	_____
G.I. Disorders:	Yes: ☐	No: ☐	_____
Autoimmune Disorders:	Yes: ☐	No: ☐	_____
Respiratory Problems:	Yes: ☐	No: ☐	_____
Neurological Conditions:	Yes: ☐	No: ☐	_____
Muscular Problems:	Yes: ☐	No: ☐	_____
Mental Health Conditions:	Yes: ☐	No: ☐	_____
Conditions of the Bones: (osteoporosis, fractures)	Yes: ☐	No: ☐	_____
Conditions of the Joints: (osteoarthritis)	Yes: ☐	No: ☐	_____
Women's / Men's Health Diagnosis or Concerns:	Yes: ☐	No: ☐	_____

Reproductive Health

What is your current reproductive health: ☐ Regular Periods ☐ Pregnant ☐ Menopause

Body Implants

Do you have a pacemaker, hearing aids, lumbar hardware, etc? _____

MRN: _____

Relationships

Are you in a supportive relationship? Yes: ☐ No: ☐ Do you have someone that you can confide in? Yes: ☐ No: ☐

Employment

Are you currently employed? Yes: ☐ No: ☐ Occupation: _____

Miscellaneous

What do you do in your free time? _____

What is your idea of mind, body, spirit connection and how does it make you feel? _____

_____

Overall, how satisfied are you with your life?

1	2	3	4	5	6	7	8	9	10

Unsatisfied — Somewhat Satisfied — Very Satisfied

Is there any other information you would like to share? _____

_____

_____

_____

_____

_____

_____

Please do not write below this line.

Practitioner Notes: _____

_____

_____

_____

_____

_____

_____

_____

_____