Client Intake Form

Name:_____ Today's date: _____

Previous yoga experience: Yes / No How long: _____

Male/Female _____ Date of Birth _____ Occupation _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Phone: _____ email: _____

Emergency Contact Information

Name: _____

Relationship: _____ Phone: _____

Medical Information

Allergic reactions: _____

Physical limitations: _____

Pregnant: Yes / No How far along: _____

Other (eg. asthma, heart condition): _____

Referrals

How did you hear about us? _____

Whom may we thank for referring you? _____