IYENGAR YOGA ASPEN HEALTH INFORMATION
INTAKE FORM

Print name_____ Date_____

New Student Yes/No If no, how many years have you studied Iyengar Yoga? _____

Occupation_____ DOB_____ Sex M/F

Please circle areas of chosen concern regarding your health. Write pertinent details below or on the back of this sheet (such as when it started, what your symptoms are etc.)

Allergy	Dizziness	Kidney	Pregnancy
Asthma	Eyes	Knees	Post-partum
Ankles/feet	Gastrointestinal	Liver	Prolonged illness
Anxiety	disorder	Lower back	Prostate
Arthritis	Headache	Low BP	Recent surgery
Auto- immune	Heart condition	Menopausal	Sedentary
dysfunction	Heel spur	Menstrual issues	Sciatica
Bladder	High BP	MS	Scoliosis
Carpal tunnel	Hips/legs	Neck	Shoulders
Chronic fatigue	HIV related	Osteoporosis	Thyroid
Diabetes	Hypoglycemia	Plantar fasciitis	Wrist/hand
Depression	Insomnia		

Please describe all surgeries (including dates) and conditions and elaborate on your condition/s:

_____

_____

List medications, remedies and supplements used:_____

Have you used? (circle answers): Acupuncture Chinese Medicine Chiropractic
Deep tissue therapy Homeopathic medicine Massage Physical Therapy Psychotherapy

Have you ever been in a car accident or had a traumatic injury? Yes/No If yes, what year? _____

Goals_____

*This form does not claim to treat any of the conditions listed above or any liability, loss, intended as a substitute for medical counseling. personal or otherwise, resulting from the yoga program.