

First Appointment Paperwork

NAME

DATE OF BIRTH

Preferred method of contact: ___ Email ___ TEXT ___ Cell Phone ___ Home Phone

MAILING ADDRESS

CELL PHONE

HOME PHONE

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NAME

RELATION

PHONE

Questionnaire

My yoga experience is _____

I would like to discuss, work on, or learn _____

The things that I have tried that HAVE WORKED are _____

The things that I have tried that HAVE NOT WORKED are _____

The feelings or emotions that arise when things don't work are _____

I feel my general health is ___ Very Good ___ Good ___ OK ___ Poor

The exercise I enjoy is _____

My exercise program is (frequency/duration) _____

The practitioners I have worked with in the recent past or currently are _____

I have experienced the following (*please check the ones that apply*)

- | | |
|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Muscle/Joint/Bone |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> Blood Problem | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sleep Issues |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Abuse of any kind (physical/sexual/emotional/verbal) |
| <input type="checkbox"/> Heart/Lung | Other: _____ |

I have not experienced any of the conditions listed above

I have a history of the following surgeries (*please check the ones that apply*)

- | | |
|---|---|
| <input type="checkbox"/> Eye | <input type="checkbox"/> Spine (e.g. Neck/Low Back) |
| <input type="checkbox"/> Abdominal/Pelvic | <input type="checkbox"/> Heart/Lungs |
| <input type="checkbox"/> Orthopedic (e.g. Knee, Shoulder) | Other: _____ |

I have no surgical history

My primary care doctor is: _____

My counselor/therapist is: _____

My stress level in the last 6 months has been Low Moderate High

My long term stress level has been Low Moderate High

I feel stressed about _____

I manage my stress with _____

I feel good about _____

I expect to recover in (% of recovery and time frame) _____

Additional Information I would like to share is _____

I heard about Yoga is Therapy/Jaimie Perkunas from _____

Consent to Treat

I agree and consent to Jaimie Perunas, DPT, e-RYT, C-IAYT & Yoga is Therapy LLC to perform yoga therapy treatment and care which includes but is not limited to: self massage, poses and exercises, postural awareness and yogic breathing. I am aware that there are risks involved in physical training. I willingly assume full responsibility for the risks that I am exposing myself to and accept full responsibility for any injury or loss that may result from performing in this yoga program. I release Yoga Is Therapy LLC & Rooted Integrative Wellness (located at 1600 N Tucson Blvd, Suite 100, Tucson AZ 85716), its employees & contractors from any & all liability, claims, demands, actions or rights of action, which are related to, arise out of, or are in any way connected with my participation in this yoga program.

I understand Telehealth is an option for appointments, which includes video and audio communication. Possible risks of Telehealth include information transmitted may not be sufficient (e.g. poor resolution of images) by deficiencies/failures of the equipment, and in very rare instances, security protocols could fail, causing a breach of the privacy.

I understand that Yoga is Therapy's services are categorized as wellness and preventative services and are not covered by health insurance companies or Medicare.

Privacy

I understand Jaimie will be taking pictures for me in poses to help create an exercises handout. These photos will be kept private. Jaimie will only share patient information with other providers with verbal or written permission from client.

I understand that Yoga is Therapy may send SMS/Text communications for appointment changes.

Cancellation & Tardiness Policy

I understand that Yoga is Therapy LLC has a minimum of a **48 hour cancellation policy** and details of the cancellation policy are available in confirmation emails, email reminders, and on Yoga is Therapy website. I understand that if I am late for my appointment, my visit will end at the scheduled time and therefore be shortened.

I have provided the information on the forms above to the best of my ability and I have read and agree to the Consent to Treat, Privacy, and Cancellation and Tardiness Policy.

Signature of Client

Date

Guardian Signature (if under 18 years old):

Date _____