Stillness and Strength Yoga, LLC

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Yoga for Survivors® Certified Instructor

Client Questionnaire

Name _____ *Birthdate* _____

Address _____ *City/State/Zip* _____

Phone _____ *Text? Yes No*

Email address _____

Emergency Contact _____ *Phone* _____

Diagnostic Information:

~Type of Cancer _____

Date of Diagnosis _____

Stage? _____

Last Platelet count: _____

Lymph involvement? Yes No _____

Oncologist _____

Surgeon _____

~Date of last Chemotherapy _____

*How many treatments have you had?*_____

How many remain? _____

~Date of last Radiation _____

How many treatments have you had? _____

How many remain? _____

Please describe any and all side effects you are currently experiencing from chemotherapy, radiation, or other therapies:

_____

_____

_____

_____

Please list any and all medications and any side effects:

_____

_____

_____

_____

Please list any cancer-related surgeries (date and type) as well as any other major surgeries:

_____

_____

_____

_____

Please list any limitations/side effects you are currently experiencing from surgery. Please include any limitations that were recommended by your doctor:

_____

_____

_____

_____

Please list any other health concerns or issues you are experiencing, particularly those for which you are taking medication or being monitored by a physician:

_____

_____

_____

_____

Aside from what is already listed, do you have any other limitations in your physical activity level, or any movements that cause you pain?

_____

_____

_____

_____

Is there a particular area of the body you'd like to focus on, to restore strength and flexibility? Please describe:

_____

_____

_____

_____

Are you able to do the following with ease/comfort (please feel free to comment):

Sit	*Yes*	*No*
Stand	*Yes*	*No*
Lie on back	*Yes*	*No*
Lie on stomach	*Yes*	*No*
Lie on right side	*Yes*	*No*
Lie on left side	*Yes*	*No*
Breathe through nose	*Yes*	*No*
Lift right arm overhead	*Yes*	*No*
Lift left arm overhead	*Yes*	*No*
Fold forward over legs	*Yes*	*No*

Aside from above, has a physician recommended that you modify/restrict your physical activities or modify/restrict any movement in any way? Describe:

_____

_____

Have you practiced yoga before? *Yes* *No*

Describe your yoga history:

_____

_____

What are your goals that we can work towards?

_____

_____

_____

_____

What are your concerns about starting your yoga practice?

_____

_____

I _____ understand that yoga includes physical movements, as well as an opportunity for relaxation, stress reduction, and relief of muscular tension. As is the case with any physical activity, the risk of injury, even serious or disabling, is always present and cannot be entirely eliminated. If I experience any pain or discomfort, I will listen to my body, adjust the posture, and ask for support from the teacher. I will continue to breathe smoothly.

Yoga is not a substitute for medical attention, examination, diagnosis, or treatment. Yoga is not recommended and is not safe under certain medical conditions. I confirm that I alone am responsible to decide whether to practice yoga. I confirm that my platelet count is at least 20,000 and all surgical incisions on my body have healed. I hereby agree to irrevocably release and waive any claims that I have now or hereafter may have against Stillness and Strength Yoga, LLC, or the instructor of my sessions.

Signature _____ Date _____

Witness _____ Date _____