

## 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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EMAIL

## Emergency Contact

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 Perkunas, 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. There will be a: **\$75 fee for a first appointment, \$62.50 fee for a follow-up appointment, \$40 fee for a check-up appointment; if I cancel between 48 and 24 hours, if I cancel less than 24 hours I will be charged the full session charge.** 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