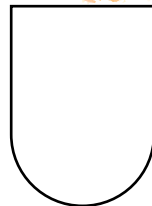




## Yoga Therapy Assessment and Review Form

First Assessment: \_\_\_\_\_ DOB: \_\_\_\_\_ Astrology: \_\_\_\_\_ Tongue: Ama Thickness: 1 2 3  
 Name: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Pulse: \_\_\_\_\_  
 Email: \_\_\_\_\_ Prakriti: V P K Vikriti: V P K  
 Address: \_\_\_\_\_ Dhatus: \_\_\_\_\_  
 Chakras: \_\_\_\_\_ Ojas: \_\_\_\_\_

☐ tremors ☐ cracks ☐ red  
☐ scallops ☐ bumps ☐ froth



### PHYSICAL:

#### CLIENT ANSWERS

#### THERAPIST COMMENTS

- |                                                                             |          |          |
|-----------------------------------------------------------------------------|----------|----------|
| 1. How my day is spent in percentages:<br>sitting, standing, lying, driving | 1. _____ | 1. _____ |
| 2. Areas of discomfort                                                      | 2. _____ | 2. _____ |
| 3. Favorite physical movement.                                              | 3. _____ | 3. _____ |
| 4. Least favorite movement                                                  | 4. _____ | 4. _____ |
| 5. Where I hold tension in my body                                          | 5. _____ | 5. _____ |
| 6. Past accidents, surgeries, other traumas<br>(state year)                 | 6. _____ | 6. _____ |
| 7. Specified physical diagnosis or chronic<br>conditions.                   | 7. _____ | 7. _____ |
| 8. Digestion                                                                | 8. _____ | 8. _____ |

### PSYCHO-EMOTIONAL:

#### CLIENT ANSWERS

#### THERAPIST COMMENTS

- |                                                                    |          |          |
|--------------------------------------------------------------------|----------|----------|
| 1. Energy levels                                                   | 1. _____ | 1. _____ |
| 2. Sleep patterns: #hrs, early/late riser                          | 2. _____ | 2. _____ |
| 3. Describe self: calm & focused, constant<br>mental chatter, etc. | 3. _____ | 3. _____ |
| 4. Specific diagnosis or contions r/t mental<br>functioning.       | 4. _____ | 4. _____ |
| 5. Describe emotional fluctuations                                 | 5. _____ | 5. _____ |

### SPIRITUAL:

#### CLIENT ANSWERS

#### THERAPIST COMMENTS

- |                                                               |       |       |
|---------------------------------------------------------------|-------|-------|
| 1. In your own words, list your beliefs:<br>"I believe ....." | _____ | _____ |
|                                                               | _____ | _____ |
|                                                               | _____ | _____ |
|                                                               | _____ | _____ |

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_