Client Information

Please complete & return to: Alexandra Oudheusden, Director of Therapeutic Recreation
Burke Rehabilitation Hospital, 785 Mamaroneck Ave., White Plains, NY 10605

Name_____ DOB_____
Address_____
City_____ State_____ Zip Code_____
Home Phone_____ Cell Phone_____
Male Female (circle one) Email_____
Emergency Contact_____ Phone_____
Relationship to participant _____
Your Physician's Name_____
Physician Phone _____ Specialty _____

Have you ever taken a yoga class? If so, when_____ and what type?_____

Do you currently exercise? If yes, please explain activities, frequency and intensity?
 Yes No_____

What is your reason for taking a yoga class? _____

___ Stress Reduction/Relaxation
___ Maintain and improve flexibility
___ Improve balance and posture/alignment
___ Connect your mind and body for better health and daily living
___ Learn how to breathe using your diaphragm
___ Improve circulation/decrease high blood pressure
___ Pain management
___ Improve bowel and bladder management
___ Decrease spasticity
___ Improve memory/alertness

I am comfortable:
- Sitting
- Standing
- Standing with assistance
- Lying on Stomach
- Lying on Back
- Lying on Side

Do you use any of the following mobility aids:
Wheelchair: Motorized or Manual
Scooter
Walker
Quad cane
Cane
Other _____

Please indicate on the chart below if you have any of the following conditions and when appropriate give additional information related to the condition…

	Check if YES	Date of Onset	Location	Specific Symptoms	Medication(s)
Cystic Fibrosis					
Neurological Disease					
Spinal Cord Injury					
Arthritis					
Joint Swelling					
Osteoporosis					
Extreme fatigue					
Decreased endurance					
Pulmonary Disease					
Cardiac or circulatory problems					
High Blood Pressure					
Low Blood Pressure					
Varicose Veins					
Epilepsy/Seizures					
Contagious Disease					
Allergies					
Skin Conditions					
Neck/Back Pain					
Hx of/current Cancer					
Numbness/pain/sensitivity					
Cognitive impairment					
Stroke					
Traumatic Brain Injury					
Bruise easily					
Visual Impairment					
Auditory Impairment					

Have you broken any bones in the past two years? □ Yes□ No Explain:_____

Have you ever had surgery? □ Yes □No Explain:_____

Do you have any other medical condition or are taking any medication we should know about?
□ Yes□ No _____

If this form was completed by someone other than the participant, please print and then sign your name below: Print _____ Sign _____