Massage & Movement Synergy
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PHYSIO-YOGA THERAPY

In order to maximize the effectiveness and safety of your sessions, please take the time to carefully fill out this questionnaire. This information will be treated confidentially. Your feedback will be appreciated during and at the end of the session to help in tailoring the session to serve in the best way possible.

Name _____ Date: _____

Address_____

City_____ State: _____ Zip Code: _____ Contact #(s):_____

Email address: _____ Occupation: _____

Age/DOB: _____ Referred by: _____

Have you worked with a yoga therapist before? _____

If you are currently taking any medication please list the medication(s) and its purpose:

Do you use an assistive device to ambulate?	Yes	No
Do you have Low Back Pain?	Yes	No
Do you have dizziness?	Yes	No
Are you pregnant?	Yes	No
Do you have high blood pressure?	Yes	No
Do you have high cholesterol?	Yes	No
Do you have Asthma?	Yes	No
Do you have Cancer?	Yes	No
Do you have Diabetes?	Yes	No
Do you have Muscle Injury?	Yes	No
Do you have Joint Injury?	Yes	No
Do you have or have you ever had a heart problem?	Yes	No
Have you ever had osteoporosis?	Yes	No
Have you ever had surgery or broken a bone?	Yes	No
Do you have rheumatoid arthritis?	Yes	No
Do you have any allergies?	Yes	No
	Yes	No

Please explain yes to any answers (use back side if necessary:

I _____, understand that my yoga therapist must be aware of existing physical conditions. I have stated all my known medical conditions and take it upon myself to keep the therapist updated on my physical health.

Signature _____ Date _____

For the following set of questions, please say as much or as little as you would like. Feel free to use the back of this paper as necessary.

Please briefly describe your illness or injury, including onset/diagnosis:

_____

_____

_____

Please describe any concerns, differences or observations you have made regarding your gross and fine motor skills as a result of your condition or as a result of medications/side effects:

_____

_____

_____

Please describe any concerns, differences or observations you have made with regard to your speech/language or cognitive skills as a result of your condition or as a result of medications/side effects:

_____

_____

_____

What do you hope to get from this therapeutic service? What would you most hope to have addressed?

_____

_____

_____

How would you describe your general emotional state and social life? How has it changed as a result of your condition? What changes would you like to make in this area?

_____

_____

I _____, understand that a therapist must be aware of existing physical conditions. I have stated all my known medical conditions and take it upon myself to keep the therapist updated on my physical health.

Signature _____ Date _____

Physio-Yoga Therapy
GOAL SETTING FORM

Rank your wellness/health/fitness goals:

Goal #1_____
Goal #2_____
Goal #3_____
Goal #4_____
Goal #5_____

How do you think each goal be achieved? (Frequency, days, times, intensity, etc)

Goal #1_____
Goal #2_____
Goal #3_____
Goal #4_____
Goal #5_____

What, if any, dietary modifications need to be made (keep them achievable and realistic)?

Goal #1_____
Goal #2_____
Goal #3_____
Goal #4_____

What obstacles might interfere with your goal achievement?

Obstacle? **What is your strategy to overcoming obstacle?**

Goal #1_____
Goal #2_____
Goal #3_____
Goal #4_____
Goal #5_____

If you've worked with a therapist/coach/instructor before, how did they help or hinder you in meeting your goals?

Goal #1_____
Goal #2_____
Goal #3_____
Goal #4_____
Goal #5_____

PhysioYoga Package Rates

Rate	Program Description
$150 (90 min) **$85 (45min)** **$100 (60 min)** **$130 (90 min)**	**Initial Evaluation** -Required for all new clients **Option A: Single Sessions -** Schedule as Needed
$70 (45 min) **$85 (60 min)** **$115 (90min)**	**5 Session Package** **Option B ($325)** **Option C ($400)** **Option D ($550)**
$60 (45 min) **$80 (60 min)** **$115 (90min)**	**10 session Package** **Option E ($600)** **Option F ($750)** **Option G ($1050)**

Billing/Payment Policy

- Sessions are billed on a monthly schedule, due at the 1st scheduled session for the month.
- Cash, Venmo, PayPal, Check or Credit Cards Accepted
- Gift Certificates are available (expires 90 days from date issued)
- $30 fee for all returned checks

Scheduling Training Sessions

- All package sessions will be scheduled on a monthly basis
- Please provide written notification by 15th of current month for next month's conflicts/cancellations

No Show/Cancellation /Late Policy

- 24 Hour notice (call, email or text) required for all cancellations
- Full charge for scheduled services if 24 notice not provided or "no show" for session
- Session times will start at the scheduled appointment time, regardless of clients arrival time, and end on schedule
- Clients arriving more than 20 minutes late for appointments will be required to reschedule appointments

Physioyoga Session and Treatment Agreement

I _____ commit to the
(Print your name here)

following yoga therapy schedule: _____.
(Write the option letter from the above list)

I understand that I will be billed on a monthly basis and payment is due at the first therapy session of each month.

I understand that this contract will renew automatically at the end of my commitment unless I notify my therapist (verbal, txt, email or written), prior to one week, of termination of this contract.

By signing this document, I attest, contract, acknowledge, and agree that I am legally bound by its content.

Signature:_____

Date:_____