LIVING ROOM YOGA

*Your Place For Yoga Therapy & Healing*

Yoga Therapy • Yoga Classes • Yoga Teacher Training • Hypnosis
Cranial Sacral Therapy • Acupuncture • The Feldenkrais Method

1608 29th Ave. North, St. Petersburg, FL 33713
(727) 826-4754 • www.livingroomyoga.biz

# New Student Form/Wellness Questionnaire for Cranial Sacral Therapy

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____ - _____

Home Phone: (_____) _____ - _____

E-Mail*: _____

Birth Date: _____

Gender: ☐ Male ☐ Female

Emergency Contact: _____

Emergency Contact Relationship: _____

Emergency Contact Phone: (_____) _____ - _____

Name of Your Healthcare Provider: _____

Phone Number of Healthcare Provider: (_____) _____ - _____

Medications You Are On and What Are They For: _____

_____

_____

_____

* Living Room Yoga uses your e-mail address to send out updates regarding your account status, reminder updates for classes or workshops you have been booked into, special promotions/coupons, and our weekly studio update newsletter. Your personal information will never be sold to a third party. You can unsubscribe from our electronic communications at any time.

What is your experience with Cranial Sacral Therapy? _____

_____

What would you like the outcome of your private appointment to be? _____

_____

If your body could talk, what would it say about its state of being? _____

_____

How is your diet and digestion? _____

Where do you have muscle pain or tension? _____

_____

How would you describe your posture? _____

_____

What kind of work do you do? _____

_____

Is your body comfortable at work? ☐ Yes ☐ No

What kind of exercise do you do, and how often? _____

_____

What do you do for stress reduction and relaxation? *Feel free to share unhealthy habits as well as healthy ones.*

_____

_____

What major surgeries have you had? _____

_____

What chronic conditions do you have?_____

_____

List any accidents or injuries with approximate dates: _____

_____

What are your main health challenges right now?_____

_____

To what extent do these challenges restrict your daily life?_____

_____

Is your schedule: ☐ Regular ☐ Irregular

Do you have any problems with breathing? ☐ Yes ☐ No

Do you notice changes in your breath when you become upset or agitated? ☐ Yes ☐ No

What happens?_____

Were you ever a smoker? ☐ Yes ☐ No

If you are still a smoker, do you want to quit? ☐ Yes ☐ No

Is your energy level: ☐ Low ☐ Medium ☐ High

Does your energy level fluctuate? ☐ Yes ☐ No

When do you have dips?_____

What are your sleep patterns like?_____

_____

Do you wake up refreshed? ☐ Yes ☐ No

Is your stress level: ☐ Low ☐ Medium ☐ High

What triggers your experience of stress? _____

_____

What do you find most effective for releasing stress? _____

_____

Do you find yourself getting upset or irritated often? ☐ Yes ☐ No

Do you experience anxiety? ☐ Yes ☐ No

Do you experience depression? ☐ Yes ☐ No

What emotions do you have difficulty experiencing or expressing? _____

_____

Are personal relationships nurturing and supportive? ☐ Yes ☐ No

Is your career fulfilling? ☐ Yes ☐ No

What are your main life challenges at present? _____

_____

What have been your most significant losses? _____

_____

Do you have friends you can confide in? ☐ Yes ☐ No

Do you notice that you keep bumping up against the same problems or situations in life?
What are they?

_____

_____

_____

What habits would you like to change? _____

_____

Do you have the big picture of your life or do you feel stuck in the forest just looking at the trees?

_____

_____

How would you describe the spiritual dimension of your life? _____

_____

What are the most important things in life? _____

_____

Do you feel like you have a particular mission in this life? _____

_____

If so, are you fulfilling it? _____

## Please Check The Goals Below That Are Most Important To You:

- ☐ Improve Digestion and Elimination
- ☐ Improve Posture
- ☐ Improve Overall Health
- ☐ Increase Body Awareness
- ☐ Improve Breathing
- ☐ Increase Energy
- ☐ Stabilize Energy
- ☐ Improve Sleep
- ☐ Handle Emotions Better
- ☐ Have a Live Experience of the Meaning of Life
- ☐ Have More Control Over the Direction of My Life
- ☐ See and Change Dysfunctional Behavior Patterns
- ☐ Have More Satisfying Personal Relationships
- ☐ Improve Diet and Develop a Healthier Lifestyle
- ☐ Reduce Experience of Stress/Attain Greater Peace of Mind
- ☐ Be Able to Feel Emotions in the Body
- ☐ Get Less Upset and Irritated
- ☐ Feel Less Anxious
- ☐ Feel Less Depressed
- ☐ Find Greater Fulfillment in My Work Life
- ☐ Improve Self Esteem
- ☐ Gain a Wider Vision of Life
- ☐ Grow Spiritually
- ☐ Have A Sense of Living Life Fully
- ☐ Muscle Strengthening (Which?)_____
- ☐ Flexibility (Where?) _____
- ☐ Joint Stability (Which?) _____
- ☐ Reduce Pain (Where?) _____
- ☐ Change Habits (Which?) _____
- ☐ Learn Specific Postures or Aspects of Yoga _____

## How Did You Hear About Us - *Please mark only one*

- ☐ Facebook Fan Page
- ☐ Referral by Member: _____
- ☐ Online Info Form
- ☐ Healthcare Provider: _____
- ☐ Driving By/Sign
- ☐ LinkedIn
- ☐ CrowdSavings
- ☐ Living Room Yoga Car
- ☐ St. Pete/Tampa Bay Times
- ☐ Tampa Bay Wellness Magazine
- ☐ Transformations Magazine
- ☐ Internet Search
- ☐ Flyer in Coffee Shop: _____
- ☐ Eversave
- ☐ LivingSocial
- ☐ Other: _____
- ☐ Bay News 9

# Cranial Sacral Therapy Liability Waiver

I am aware that cranial sacral therapy may temporarily increase my pain or cause me to revisit pains from past injuries on my way to healing. I understand that during treatment, I may experience a myriad of sensations including heat or pulsing and that this is an indication of a therapeutic result. I certify that I have disclosed all relevant health problems to Living Room Yoga prior to beginning the program, so the therapist can adjust treatment appropriately. I agree to take responsibility for my own safety by letting the occupational therapist know if I experience pain or discomfort. I acknowledge that the occupational therapist has not and will not render medical services, including medical diagnosis of my physical condition. I specifically agree that Living Room Yoga shall not be liable for any claim, demand, cause of action of any kind whatsoever for, or on account of death, personal injury, property damage, or loss of any kind resulting from or related to my use of equipment or participation in cranial sacral therapy on the premises of Living Room Yoga. I agree to hold Living Room Yoga harmless from same.

I have read the above release and waiver of liability and fully understand its contents. I signify by signing below that I voluntarily agree to the terms and conditions stated above from this date forward in all my dealings with Living Room Yoga.

**Printed Name**

**Signature** **Date**

# Cancellation Policy Acknowledgement

By signing below, I agree to provide notice of cancellation by **Noon of the previous business day** in order not to be charged for the missed session. Weekend and Monday appointments must be cancelled by 12:00 noon on the Friday before in order not to be charged for the appointment.

**Printed Name**

**Signature** **Date**