Stephanie Kincade, Yoga and Ayurveda Specialist Intake Form

Please answer to the best of your ability

PLEASE PRINT

Name:_____ Date: _____/_____/_____

Adress:_____ Prov.:_____ City:_____

Postal Code:_____-_____ Country:_____ Email:_____

Phone No.: (cell)_____(home)_____(work)_____

Time of Birth:_____AM/PM Place of Birth:_____

Marital Status:_____Occupation:_____

How did you hear about me? _____

Please list any other practitioners you are seeing and what for: _____

_____

Please list the main health problems you would like to address/be free of in order of importance:

1. _____

2. _____

3. _____

How and when did these conditions begin? _____

Health Professionals seen for them:_____

Please describe your yoga practice:_____

_____

Stephanie Kincade, Yoga and Ayurveda Specialist Intake Form

Please describe your daily diet (typical meals and snacks you may have in a day and when):

_____

_____

Please consider the following questions: How many times a day do you eat? Is food hot or cold? How many meals a week do you eat out? Typical beverages? What are your favourite 'go to' or comfort foods?

Please describe your meditation/spiritual practice:_____

_____

Please describe your recreational activities and/or hobbies:_____

_____

What other information do you think would be helpful to understand about your history or current situation? _____

_____

_____

_____