



MIND INTO MATTER

## Student Intake Form

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Your yoga training experience will be life changing. Please share what is important for us to know about you. We will hold your information in confidence and we will support your learning journey in every way possible. For every teacher there is a purpose. We will help you find yours.

### Section 1: Personal Details

Name	Date of Birth
Address	City
State/Province	Country
Postal Code	Home Phone
Cell Phone	Work Phone
Email Address	Occupation
Emergency Contact Name	Emergency Contact Phone



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## Section 2: Your Yoga Experience | Goals | Purpose

What has prompted you to commit to taking our yoga teacher training?

What do you hope to take away from this experience?

Do you wish to teach yoga once you complete this training? If so, where?

If you feel you know what your life purpose is, please share it here.

How often do you practice yoga now? (Daily? Weekly? Monthly?)

Have you practiced with Fiji's videos online at [DoYogaWithMe.com](http://DoYogaWithMe.com)?

What style(s) of yoga do you practice most frequently? (Highlight all applicable.)

*Hatha Ashtanga Vinyasa/Flow Iyengar Power Anusara*

*Bikram/Hot Kundalini Gentle Restorative Yin*

*Other (Explain)*



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What are your goals, expectations and benefits for your yoga practice? (Highlight all applicable.)

*Strength Training   Flexibility   Balance   Stress Relief   Health Concerns*

*Alternative Therapy   Improve Fitness   Weight Management   Wellness*

*Injury Rehabilitation   Positive Reinforcement*

*Other (Explain)*

What personal yoga interests do you have? (Highlight all applicable.)

*Asana (Postures)   Pranayama (Breath Work)   Meditation   Yoga Philosophy*

*Eastern Energy Systems*

*Other (Explain)*

How has your yoga practice served you in your life?



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### Section 3: Lifestyle | Fitness | Physical History

Do you smoke cigarettes?

- Yes
- No

Do you consume alcohol?

- Yes
- No

Do you use drugs? If so, what types, and how often? Please be honest as this is confidential!

How do you rate your current level of physical activity? (Highlight applicable.)

*Sedentary    Somewhat Inactive    Somewhat Active    Extremely Active*

On a scale of 1-10, (1 is lowest, 10 is highest) how would you rate your level of stress? (Highlight applicable.)

1   2   3   4   5   6   7   8   9   10

Does your Physician or Health Care Provider know you will be doing yoga?

- Yes
- No

Are there any movements that have been advised against or restricted to do?



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Please review this list and check those conditions that have affected your health either recently or in the past. (Highlight all applicable.)

- Broken/Dislocated Bones    Diabetes Type 1 or 2    Pregnancy    Insomnia*
- Muscle Strain/Sprain    High/Low Blood Pressure    Surgery    Seizures*
- Arthritis/Bursitis    Disc Problems    Neck/Back Problems    Stroke    Scoliosis*
- Asthma/Shortness of Breath    Anxiety/Depression    Heart/Lung Conditions*
- Numbness/Tingling Anywhere    Osteoporosis    Chronic Pain    Severe Allergies*
- Chronic Illness    Joint Problems    Headaches    Seizures/Loss of Consciousness*
- Thyroid Condition    Physical Trauma    Mental Health Conditions    Cancer*
- Auto-Immune Condition\* (e.g.: AIDS, Fibromyalgia, Chronic Fatigue, Lupus, etc.)*
- Other (Explain)*

Please provide details of conditions highlighted above.

Are you currently taking any medications?

- Yes
- No

If yes, please list names and reason for medications.



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## Section 4: Dietary Preferences | Food Allergies

Please highlight your preferences below. (Highlight all applicable.)

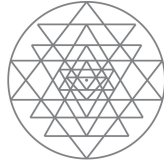
*Vegetarian*   *Vegan*   *Halal*   *Kosher*   *Gluten-Free*   *None*

*Other (Explain)*

Please highlight or list any food allergies below. (Highlight all applicable.)

*Peanuts*   *Dairy*   *Gluten*   *Shellfish /Crustaceans*   *Soy*   *Eggs*   *Wheat*

*Other (Explain)*



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## Section 5: Concluding Remarks

How did you learn about our Yoga Teacher Training?

Please share anything further that is important for us to know at this time.

Thank you for your transparency and trust. Namaste.