Client Consultation Form and Physical Activity Readiness Questionnaire

iUSP147 – Programming yoga teaching sessions

Centre name:	
Centre number:	
Learner name:	
Learner number:	
Date:	

Client name:		
Address:		
Profession:		
Telephone number:	Day:	
	Evening:	

Personal details:						
Age group:	Under 20 ☐	20 – 30 ☐	30 – 40 ☐	40 – 50 ☐	50 – 60 ☐	60+ ☐
Lifestyle:	Active ☐			Sedentary ☐		
Last visit to the doctor:						
GP address:						
Number of children: *(If applicable)*						
Date of last period: *(If applicable)*						
How often do you exercise?	None ☐	Regular ☐	Occasional ☐	Irregular ☐		
	Type:					

Contra-indications requiring medical permission – with medical, GP or specialist permission **-** *in circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment (Select if/where appropriate):*					
Any recent injuries including fractures, strains, sprains, ruptures or tears	☐	Diarrhoea	☐	After a heavy meal	☐
Fever	☐	Any musculoskeletal problems including joint or back pain	☐	Under the influence of alcohol	☐
Any contagious diseases or infections	☐	Any chronic joint problems	☐	If overtired or exhausted	☐
Any undiagnosed illness	☐	Any pain and soreness in muscles caused by trauma or injury	☐	If under the influence of painkilling drugs	☐
Vomiting	☐	Slipped disc	☐	If taking strong painkillers	☐

A medical check-up should be sought before starting an exercise programme especially for people with the following – *(Select if/where appropriate):*					
Heart condition or any history of heart disease	☐	Obesity	☐	Any history of lung problems including asthma, bronchitis and emphysema	☐
High blood pressure	☐	Whiplash	☐	Smoker	☐
Any condition being treated by a medical practitioner	☐	History of heart problems in the immediate family	☐	Clinical depression	☐
Trapped/pinched nerve (sciatica)	☐	Hypertension	☐	If there has been any past difficulty with exercise	☐
Any inflammatory joint conditions including arthritis, rheumatoid arthritis and osteoarthritis	☐	Diabetic	☐	Pregnancy – medical permission must be sort before continuing	☐
Any neurological disorders including strokes, multiple sclerosis unless medically supervised	☐				

Written permission required by – *Either of which should be attached to the treatment form (Select if/where appropriate):*			
GP/specialist	☐	Client disclaimer	☐

Personal information – *(Select if/where appropriate):*				
Muscular/ Skeletal problems:	Back ☐	Aches/pain ☐	Stiff joints ☐	Headaches ☐
Digestive problems:	Constipation ☐	Bloating ☐	Liver/gall bladder ☐	Stomach ☐
Circulation:	Heart ☐	Blood Pressure ☐	Fluid retention ☐	Tired legs ☐
	Varicose veins ☐	Cellulite ☐	Kidney problems ☐	Cold hands and feet ☐
Gynaecological:	Irregular periods ☐	P.M.T ☐	Menopause ☐	H.R.T ☐
	Pill ☐	Coil ☐	Other:	
Nervous system:	Migraine ☐	Tension ☐	Stress ☐	Depression ☐
Immune system:	Prone to infections ☐	Sore throats ☐	Colds ☐	
	Chest ☐	Sinuses ☐		
Regular antibiotic / medication taken?	Yes ☐	No ☐	If yes, which ones?	
Herbal remedies taken?	Yes ☐	No ☐	If yes, which ones?	
Ability to relax:	Good ☐	Moderate ☐	Poor ☐	
Sleep patterns:	Good ☐	Poor ☐	Average no. of hours	
Do you see natural daylight in your workplace?	Yes ☐	No ☐		
Do you work at a computer?	Yes ☐	No ☐	If yes, how many hours?	
Do you eat regular meals?	Yes ☐	No ☐		
Do you eat in a hurry?	Yes ☐	No ☐		
Do you take any food/vitamin supplements?	Yes ☐	No ☐	If yes, which ones?	
How many portions of each of these does your diet contain per day?	Fresh Fruit	Fresh Vegetables	Protein	Source of protein:
	Dairy produce	Sweet things	Added salt	Added sugar

How many units of these drinks do you consume per day?	Tea		Coffee		Fruit juice		Water	
	Soft drinks				Others			
Do you suffer from eating disorders?	Yes ☐				No ☐			
Bingeing?	Yes ☐				No ☐			
Overeating?	Yes ☐				No ☐			
Do you smoke?	Yes ☐		No ☐		How many per day?			
Do you drink alcohol?	Yes ☐		No ☐		How many units per day?			
Do you exercise?	None ☐		Occasional ☐		Irregular ☐		Regular ☐	
	Types:							
What is your skin type?	Dry ☐		Oily ☐		Combination ☐			
	Sensitive ☐				Dehydrated ☐			
Do you suffer/have suffered from:	Dermatitis ☐		Acne ☐		Eczema ☐		Psoriasis ☐	
	Allergies ☐		Hay fever ☐		Asthma ☐		Skin cancer ☐	
Stress level: 1- 10 (10 being the highest)	At work				At home			

iUSP147 – Yoga Recommendations

Details of recommended yoga asanas	Rationale	Alternatives	Expected progression	Achieved progression

Details of how the client felt during and after each session:

Details of home care advice given after each session:

Overall conclusion should include:		
Recommendations for future yoga asanas	**Progressions**	**Reflective practice**

Instructor signature: _____

Client signature: _____

Date: _____

iUSP147 – Follow-up Sheet

Details of recommended yoga asanas	Rationale	Alternatives/variety	Progression expected	Progression achieved

Details of how the client felt during and after each session:

Details of home care advice given after each session:

Overall conclusion should include:		
Recommendations for future yoga asanas	**Progressions**	**Reflective practice**

With medical, GP or specialist permission – ***in circumstances where written medical permission cannot be obtained the client must sign an informed consent stating that the performance and its effects has been fully explained to them and confirm that they are willing to proceed without permission from their G.P. or specialist***

Instructor signature: _____

Client signature: _____

Date: _____

Document History

Version	Issue Date	Changes	Role
v1	27/09/2019	First published	Qualifications Administrator