



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Yoga for Cancer: CONFIDENTIAL INTAKE FORM

WELCOME! The following information will allow us to provide an effective and enjoyable yoga experience. If at any time you have questions regarding your session, please let us know. If you have any questions or concerns, please contact Jessie Lu, jgalbraith@whatcomymca.org.

First & Last Name _____

Email _____ Phone _____

Emergency Contact First & Last Name _____ Emergency Contact Phone _____

Age (please circle one)	Identify As (please circle one)	
Below 40	She/Her	
41-65	He/Him	
66-80	They/Them	
Over 80	Other	
Gender (please circle one)	Race/Ethnicity (please circle one)	
Female	Asian	Native American
Male	Black (not Hispanic)	Pacific Islander
Other	Hispanic	White
Prefer not to answer	Multiracial	Other

Please let us know a little about your cancer journey in order for us to provide modifications if necessary.

Why are you taking this class? (circle all that apply)	Have you practiced yoga before? (please circle one)	How often do you practice yoga?
Doctor Recommended	Yes	None
Friend Recommended	No	Daily
Love Yoga	If yes, when was your last class?	Weekly
Cost		Monthly

What are your goals or benefits you are looking for? (please circle one)	Are you a cancer (circle all that apply)	
Flexibility	Weight Loss	Patient
Strength	Healing	Survivor
Focus	Relaxation	Caregiver

Please complete page 2.

If you are a patient or survivor, please tell us a little bit about your diagnosis and where you are in your treatment.

If you are a patient or survivor, do you currently have a pic line, port or other device?
(please circle one)

No Yes

If yes, please explain _____

Do you have any physical challenges/injuries you are managing? (please choose one)

None One Several

If one or more, please share what you are managing to help our instructor provide adaptations/modifications if necessary.

Is there any other information you wish to share?

Signature: _____ Date: _____