



## Yoga Therapy Request

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Precautions/Contraindications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Address the following areas of concern: (write in or check below)

Stress reduction

chronic pain

Fatigue

ROM

Posture Education

Relaxation techniques

Balance training

Neurological Disorder

Strength training

specify: \_\_\_\_\_

Physician's  
signature \_\_\_\_\_ Date \_\_\_\_\_