



*Sierra Bender*

**Wholistic Yoga Therapy Training**

**Application**

**Fax completed applications to (570) 685-9685. Please call first.**

Sierra Bender Wholistic Yoga Therapy Teacher Training is not just about learning yoga postures, it is an intensive healing process. WYTT is more than just physical exercise, it is a way to treat, heal and challenge all aspects of yourself to work to your true potential.

The more honest and forthcoming you are with these questions the better we will be able to work together on your personal journey of whole self health. You will grow tremendously if you are open to the benefits and experiences of this intense training.

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

**Emergency Contacts:**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Therapist: \_\_\_\_\_ Telephone: \_\_\_\_\_



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**Background Information:**

**Name:** \_\_\_\_\_

1. What is your occupation: (If you're not currently employed, your past profession or training)

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2. How did you find out about this program?

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3. What is your definition of Yoga? Do you consider Yoga a religion?

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4. Previous yoga programs taken: teachers, style, where, when, and duration:

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5. Are you a Yoga teacher? If so, please describe in detail your classes and previous training experience. How long have you been teaching? What tradition?

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**Name:** \_\_\_\_\_

6. How has your experience of Yoga changed and developed over time? How has it impacted your life?

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7. Do you have a personal home Yoga practice? If so, how long have you been practicing? Please describe your practice and style.

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8. Do you have a regular meditation and Pranayama practice? If so, how long have you been practicing? Please describe your practice and style

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9. Why did you choose Sierra Bender Wholistic Yoga Therapy Training at this time?

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**Health Information:**

**Name:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Please indicate any conditions that apply to you:**

Pregnancy: \_\_\_\_\_ months at start of program. Complications: \_\_\_\_\_

Present medical treatment or supervision:

Conditions and for how long:

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Physical limitations (movement, vision, hearing, etc.):

Nature, duration, and extent of limitation:

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Communicable diseases, serious or chronic illness or major surgery within the last five years:

Conditions and dates:

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Drug or alcohol addictions:

Length of abuse, date of sobriety, and treatments:

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**Health Information:**

**Name:** \_\_\_\_\_

List any prescription medications:

Dosage & how often:

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Do you come from an abusive background (sexual, physical, verbal, emotional, etc.):

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Current psychotherapy, counseling, psychiatric treatment or hospitalization:

Condition or reason, dates and duration:

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Chronic fatigue, migraines, menstrual difficulties, eating disorders, hormonal imbalances or any other conditions:

Date of onset and duration:

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