Light of Light Yoga Therapy Intake Form

Welcome! As a means of better serving you, please answer as many of the questions below as is comfortable for you. Once completed, please email the form back to me at least two days before our first meeting. Your personal information is absolutely confidential. It is for professional use only.

Many thanks,
Joy Sciabica joy@lightoflightyoga.com

Full name [redacted] Age 47 Personal Pronouns she/her Date: 4/13/24
Email address: [redacted]
Home address: [redacted] PA [redacted]
Phone number: [redacted] other
Occupation (previous if retired) Clinical Quality Supervisor [redacted] Psychologist)
Emergency contact: Name: [redacted] Phone number: [redacted]

Yoga ~~~~~~

What motivated you to begin yoga therapy at this time?

A desire to utilize yoga to help reduce chronic pain, decrease impacts of stress & anxiety, improve mood, and add to mindfulness efforts.

Are there any particular benefits you hope to derive from yoga therapy?
Possibly- Stress reduction, strength, flexibility, balance, focus, process loss/grief, reduce anxiety symptoms, ease depression, improve posture, mindfulness and meditation, address a specific medical condition.

Reduce chronic pain, decrease anxiety & improve mood

Have you practiced yoga before? **Yes** No
Do you currently practice yoga? Yes **No** (very infrequently)

If you have any concerns about participating in yoga therapy, please briefly describe them below.

No concerns at this time

Health and Well-Being~~~~~~

Current level of physical activity.
Please indicate your level of physical activity on a scale from 1 to 5 as described below.
1=inactive/sedentary, **2**=light, **3=moderate**, **4**=strenuous, **5**=endurance.

Exercise Routine
Do you have an exercise routine? **Yes** No (somewhat)
If yes, please describe. Such as activities, frequency, self-directed or guided, duration, intensity.

— I do at home workouts through a membership with Team Body Project. Workouts are typically a mix of cardio & some hand weights, for ~30 minutes, a few times a week. I also take walks, and in the winter enjoy skiing.

Mobility

Are any functional movements and tasks difficult for you? For example: lowering to the floor, getting up from the floor, reaching, bending, twisting, walking, going up or down stairs, standing, getting in/out of a car. Yes **No**

If yes, please describe.

Daily Routine

Do you have a typical waking routine? Yes **No** (I walk my dog on short walks and sometimes take longer walks with my neighbor or husband)

Do you have a typical preparation for sleep routine? **Yes** No (somewhat, though my bedtime and routine is not consistent)

Do you have a typical mealtime schedule? Yes No (somewhat - lunch times can vary, but otherwise a fairly consistent time for breakfast & dinner)

Sleep

How many hours do you usually sleep each night? 7-8

On average, what time do you go to sleep and wake up? Sleep time 10pm Wake time 6am

Do you have difficulty falling asleep? Yes **No**

Is your sleep typically interrupted? **Yes** No

If your sleep is interrupted, what usually wakes you up?

Not always sure. Sometimes my cpap mask being out of position, sometimes temperature, occasionally to go to the bathroom or due to bad dreams.

Do you typically wake up feeling refreshed? Yes **No** (a few times per week I might, but often I do not)

Eating Patterns

Would you like to make any changes to your eating patterns? Such as eating schedule, frequency of eating, aligning eating patterns with overall wellness goals.

Yes No

If yes, you are welcome to describe your goals in this area.

I'd like to work on incorporating more protein into my diet throughout the day, being better in tune with hunger & fullness cues, and more chewing of my food.

Energy level

Please indicate your *overall energy level*. On a scale from 1 to 5 as described below.

1=Very low/lethargic, **2**=Low/fatigued, **3=Moderate**, **4**=High, **5**=Very High/Overdrive

When are you most energized? In the morning, after I've been awake for 30-60 minutes

When are you least energized? evening, though sometimes slump in afternoon

Stress

Please indicate your *overall stress level*. On a scale from 1 to 5 as described below.

1=No stress, **2**=low/minimal, **<u>3=Moderate</u>**, **4**=High, **5**=Very High

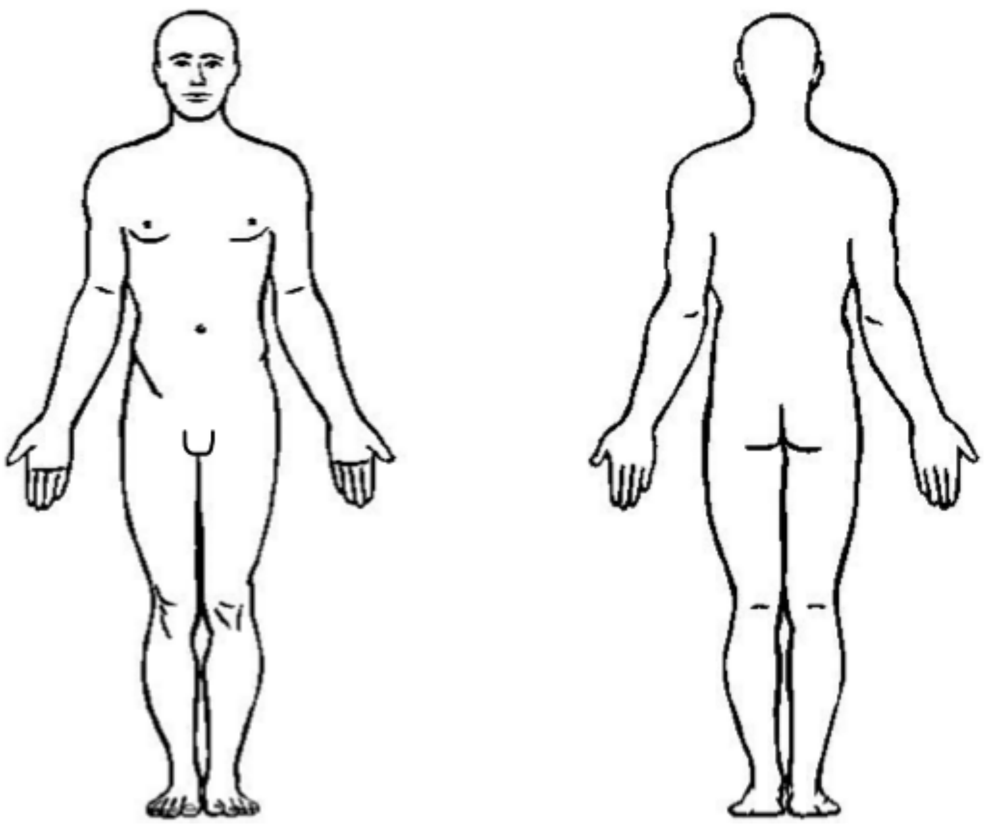
Are there any specific life circumstances contributing to your stress level now? **<u>Yes</u>** No
If yes, you are welcome to describe your primary stressors.

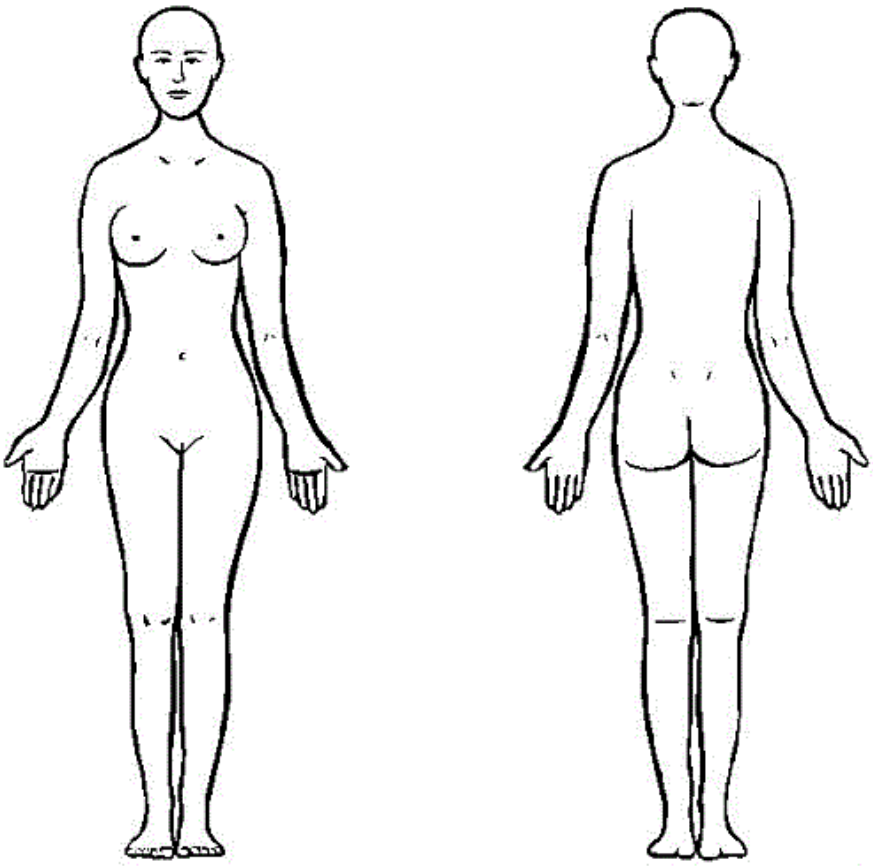
Work/being the primary earner in my family, relationship issues (in marriage counseling currently, which has been quite helpful),worries about the future (e.g., financial security; things related to my kids); pain (see below)

What do you do to cope with the stress in your life?

Worrying, lol (not the most effective strategy, but it's something I do); regular individual & couples therapy; once a week online meditation & journaling group; exercise; spending time outdoors; spending time with my dog & people I love; talking to friends; hot epsom salt baths; uses of sauna; trying to reduce chronic pain

Physical and Mental Health ~~~~~~
Health conditions. You may describe areas of pain, numbness, or discomfort here:





Often have low back pain or tightness, same w/ my neck & upper back/shoulder, headaches, right wrist pain (recently diagnosed with ulnar impaction syndrome), my hips are always tight, have dealt with plantar fasciitis flares, though this has generally been ok lately

Do you have a history of any of the following? Please check all that apply.

Allergies	Elimination~ **constipation**, diarrhea	Neuropathy, tingling, numbness
Anxiety or panic attacks	Eye disease	Osteoporosis, osteopenia
Arthritis	Fatigue, lethargy, low energy	**PMS**/Menstrual pain
Asthma	Head injury~ TBI, concussion(s)	Respiratory condition(s)
Cancer, Type	**Headache**, migraines	Sciatica
Chronic Pain	Heart disease	Seizures
Circulatory issues, swelling	High blood pressure	Stroke
Depression	Insomnia, **sleep issues** (sleep apnea)	Thyroid condition(s)
Diabetes	Joint pain	Urinary condition(s)
Digestive/ gastrointestinal illness	Memory issues	**Weight concerns**
Difficulty concentrating/ focusing (diagnosed with ADHD in the past year)	Muscle pain, stiffness, cramping	Other
Dizziness/vertigo	Neurological disease	

Are you seeing a health care provider for any of the above or other conditions? **Yes** No
If yes, please list any diagnoses, type of provider, and current treatments.

I see a chiropractor 1-2 x / month; I see an individual therapist weekly; I see my sleep doc yearly (sleep apnea is well managed with cpap therapy)

Have you tried other integrative therapies such as acupuncture, chiropractic care, massage therapy, or ayurveda? **Yes** No
If yes, please note the type of care and its effects.

Chiropractic care, acupuncture & massage

Have you had any surgeries, major injuries, or hospitalizations? **Yes** No
If yes, please note when and briefly describe each.

Hospitalized for 5 days in 2021 for pancreatitis & subsequently had my gallbladder removed soon after

2011: Hospitalized for pregnancy complications & then an emergency c-section (our daughter died at birth)

2003: Surgery to remove benign hand tumor

1994: broken jaw that was wired shut

Do you have a history of trauma or current/ongoing traumatic circumstances in your life?
Yes No (history of; non current circumstances)

Do you have a history of substance abuse/addiction? Yes No (please see below)
Are you in recovery presently? Yes No

Do you consume any of the following substances: alcohol, **caffeinated beverages**, tobacco products, or marijuana? **Yes** No
If yes, please note the substance and typical daily or weekly consumption of each below.

I stopped drinking in 2018. I do not identify as an alcoholic or in recovery, but as a non-drinker. I was a problem drinker for many years, with bouts of binge drinking.

Are you receiving professional psychiatric care for any of the above or other mental health concerns? **Yes** No
If yes, please list any diagnoses and current treatments related to your mental health.

Anxiety, depression, & ADHD

Please list any prescription medications, vitamin, and/or herbal supplements you take.

Vyvanse, Singulair, Vitamin D. Elderberry gummies, Ashwagandha, & Curcumin

If you would like to share any significant events that have shaped your life, please do.

Wisdom and Intellect ~~~~~~
What are you learning, curious about, and/or teaching others?

Learning about tarot cards & readings
Learning about ways I can support other cpap users to help them adhere to cpap treatment
Learning about burnout & vicarious trauma

Do you like to read, listen to audio books, and/or listen to podcasts? **Yes** No (all of the above, but lately I've been enjoying reading various fiction books & occasionally listening to podcasts)

Community and Social Engagement ~~~~~~
Are you connected to an accessible social support network such as family, friend groups; church, special interest, or charity/volunteer groups? **Yes** No (however, I don't feel like I have a true community here in State College, and I have longed for this for quite some time)

Do you have a pet? Y**es** No

Is loneliness a concern for you? **Yes** No

Spirituality and Mindfulness ~~~~~~
Do you have a spiritual practice? This could range from strong religious affiliation to experiencing the wonders of the natural world. **Yes** No
If yes, please briefly describe.

I believe in the universe, spirit guides, the power of nature. I do not participate in organized religion, but was raised going to a United Church of Christ regularly.

What aspects of your life are meaningful to you? Things tied Ito my core values around love, family, adventure, kindness, humor and curiosity

What inspires you?

Do you have any special interests that allow you to express yourself in a uniquely personal or creative way? For example, playing an instrument, crafts, writing, cooking, home design, gardening, singing, visual arts, dance, outdoor activities, sports, etc. **Yes** No If yes, please briefly describe.

I am currently trying to cultivate more creativity in my life. I enjoy writing, drawing, creative lettering, music (would love to take singing lessons!), being in nature, dogs, kids, & sports

Mindfulness and Meditation

Do you practice mindfulness or meditation? **Yes** No

If yes, please briefly describe.

I attend a weekly online mediation group (The Artist Morning community) where we do 20 minutes of meditation & then 20 minutes of journaling. It is wonderful!

If no, are you interested in exploring meditation? Yes No

Anything else?

You are welcome to share any other related thoughts, questions, or concerns that you may have.

Just want to say how much I love all the questions you included on this form :)

~~~ Many thanks for your responses. ~~~