Blossoming Lotus
Intake and Assessment
703-606-1698
Tia@BlossomingLotus.yoga

MML 003

1 of 9

BASIC PERSONAL INFORMATION			
Name:		Date:	Clinician ONLY Preferred Name: MML-003
Age: 64	Gender Identity: Female	Who referred you? ☒ Self ☐ Clinician: ____ ☐ Other: ____	Preferred Pronouns: She/her
What major concerns do you wish to address through Yoga: ☒ Physical: Strength ☒ Emotional: Calm ☒ Mental: Centered ☐ Spiritual: ____ ☐ Relationship: ____ ☐ Other: ____	What are your three main goals* for yoga therapy: Strength Flexibility Calm	What is your intention** in seeking yoga therapy: > Significantly decreased after M. died - reduce stress	Notes: 8:00a

YOGA PRACTICE BACKGROUND			
How long have you practiced? ☐ No experience – 0 years ☒ < 1 year ☐ 1-3 years ☐ 4-5 years ☐ 6-10 years ☐ >10 years	How often do you practice? ☒ Not applicable (N/A) ☐ < 1x per week ☐ 1-2x per week ☐ 3-4x per week ☐ >5x per week ☐ Other: ____	How long is each session on average? ☒ N/A ☐ 15-30 minutes ☐ 31 to 45 minutes ☐ 46 to 60 minutes ☐ 61 to 90 minutes ☐ Other: ____	Clinician ONLY Notes:
What is your favorite kind of yoga? ☐ Chair ☐ Gentle ☒ Power ☐ Other/N/A: ____	Where do you practice most? ☐ Yoga studio ☐ Fitness/Rec Center ☒ Home on my own ☐ Online ☐ Other/N/A: ____	Do you have other mind-body practices? e.g.,: ☐ Martial Arts ☐ Tai Qi ☒ Other/N/A: Pilates ☐ Meditation ____	Likes/dislikes related to practice? Stretch/strength mindfulness

*Goal - desired outcome you wish to attain further into the future.

**Intention - chosen theme that allows you to create alignment in your life.

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Circle how often you engage in the following yoga practices:

Practice	Often	Sometimes	Never
Aspiring to lead an ethical life	**(Often)**	Sometimes	Never
Living in a nonviolent way	**(Often)**	Sometimes	Never
Being truthful	**(Often)**	Sometimes	Never
Not taking what is not freely offered to me	**(Often)**	Sometimes	Never
Living in moderation	**(Often)**	Sometimes	Never
Not being greedy	**(Often)**	Sometimes	Never
Aspiring to lead a purposeful life	**(Often)**	Sometimes	Never
Living with purity (eating healthy food or keeping a clean living space)	**(Often)**	Sometimes	Never
Living with equanimity (remaining calm, not getting attached)	**(Often)**	Sometimes	Never
Living with discipline (having a regular routine, sports or meditation)	**(Often)**	Sometimes	Never
Living with introspection (paying attention to my thoughts and feelings)	**(Often)**	Sometimes	Never
Living with purpose (dedicating myself to creating meaning)	**(Often)**	Sometimes	Never
Aspiring to a life that honors the health and wellness of my body	**(Often)**	Sometimes	Never
Posture (asana) practice	Often	**(Sometimes)**	Never
Aspiring to a life in which mind and body connect	**(Often)**	Sometimes	Never
Breathing practices	Often	**(Sometimes)**	Never
Aspiring to a life of mindful introspection	Often	**(Sometimes)**	Never
Becoming quiet and looking inward	**(Often)**	Sometimes	Never
Avoiding too much stimulation	**(Often)**	Sometimes	Never
Aspiring to a life of concentrated awareness	Often	**(Sometimes)**	Never
Practices such as guided imagery or relaxation training	Often	**(Sometimes)**	Never
Practices such as body scans or other body awareness exercises	Often	**(Sometimes)**	Never
Aspiring to a life of meditative awareness	Often	**(Sometimes)**	Never
Aspiring to a life that connects body, mind and spirit	Often	**(Sometimes)**	Never
Sitting in meditation	Often	**(Sometimes)**	Never
Walking in meditation	**(Often)**	Sometimes	Never
Experiencing a connection to a greater whole—feeling complete	Often	**(Sometimes)**	Never

Goals for practice

Now:
box breathing

clear brain while moving
"meditation in motion"

→ some apps; sometimes when "I" need a minute to breathe + reset.

→ 420

PHYSICAL HEALTH INFORMATION

Who is your primary care provider:
Name: Su Yi
Address: Vienna, VA
Contact information:

If you do not have a PCP, would you like us to make a referral:
- ☐ Yes, please
- ☐ No, thank you
- ☐ Ask me later

CLINICIAN ONLY
Make PCP referral OR
Obtain release of information as needed

Are you struggling with any of the following:

- [ ] Addiction / alcohol / drugs
- [x] Adrenal fatigue / illness
- [ ] Allergies
- [ ] Anxiety
- [ ] Arthritis
- [ ] Autoimmune disease
- [ ] Cancer
- [ ] Chronic Pain
- [ ] Dementia
- [x] Depression
- [ ] Diabetes
- [ ] Digestive/gastrointestinal illness
- [ ] Eating disorder / anorexia / bulimia
- [x] Head injury
- [ ] Heart disease
- [ ] High blood pressure
- [ ] High cholesterol
- [ ] HIV/AIDS
- [ ] Kidney disease
- [ ] Liver disease / hepatitis
- [ ] Lung disease / Asthma / COPD
- [x] Menopause
- [ ] Musculoskeletal concern
- [ ] Movement Disorder
- [ ] Neurological disease
- [ ] Osteoporosis
- [ ] Schizophrenia
- [ ] Sciatica
- [ ] Skin problems
- [ ] Sleep problems
- [ ] Stroke
- [x] Thyroid issues
- [ ] Vision problems / eye disease
- [ ] Weight concerns
- [ ] Other: ______

Have you had surgeries? If yes, please describe, date

Knee 2015
Ankle 2005
Ulcer 1976
OvarianCysts 1998

Have you been hospitalized? If yes, please describe the reason, date, how long:

Surgery 1998, 2005

When was your last (approximately):

- [x] Physical exam: 3/24
- [x] Vision exam: 3/23
- [x] Dental check-up: 3/24
- [ ] Hearing test:
- [ ] Other:
- [ ] Other:

Have you had any injuries or accidents? Please list, date:

- [ ] Right knee 2015
- [ ] Right Ankle 2005
- [ ] Concussion -12/23
- [ ] most recent

What medications are you currently taking: (please list all; OPTIONAL: reason)

- [ ] Oxybutnin
- [ ] Synthroid
- [ ] Sertaline
- [ ] Estradiol

What supplements (e.g., vitamins, minerals, herbs) are you currently taking: (OPTIONAL: reason, dosage)

- [ ] Omega-3
- [ ] Magnesium
- [ ] B-vitamin
- [ ] Tumeric

Follow up on all endorsed items

Ask about alcohol and smoking

Do you have limitations in physical activity level? If yes, please describe.

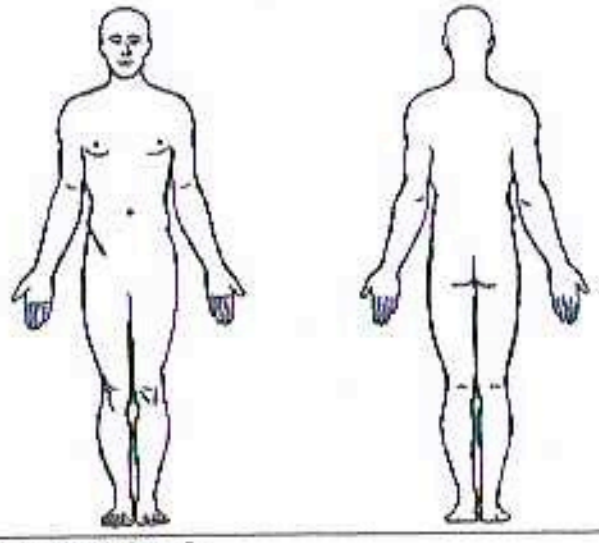
N/A

Explore if movement aggravates or relieves

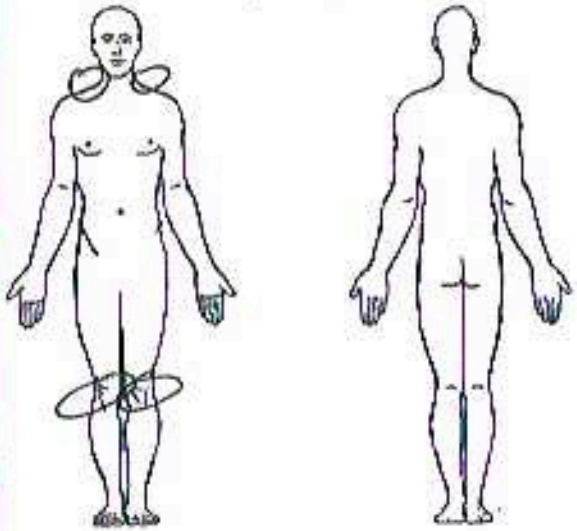
Client: MML

Blossoming Lotus

Please mark where you currently experience ACUTE pain



Please mark where you experience CHRONIC pain *



Ask for pain rating from 1 to 10 for each indicated area:

Explore if movement aggravates or relieves:

How is your sleep?

Wake-up time: 7:30 AM

Do you use an alarm to wake: yes (no)

Bedtime: Weekdays 9:30-10:30 ish pm

Do you fall asleep easily? (Yes) no

Hours of uninterrupted sleep per night? 4-5

Do you feel tired upon waking? (Yes) no

Explore quality of sleep:

reads @ bedtime

- ☐ Initial insomnia
- ☐ Middle insomnia
- ☐ Terminal insomnia

awakens at night; no TV

- ☐ Night terrors, sleep walking
- ☐ Other sleep disturbance

room is too hot

How much do you move every day?

How many hours do you sit each day (at work plus at home): 10 hours

Can you move as well as you would like? yes (no)

What types of exercise do you do:

Type: Soccer times per week: 3-4

number of minutes each time: 90

Type: _____ times per week: _____

number of minutes each time: _____

Type: _____ times per week: _____

number of minutes each time: _____

How is your nutrition (food and drink)?

Typical breakfast: 2 eggs OR - bowl of cereal

Typical lunch: yogurt + berries

Typical dinner: protein + 2/3 vegetables

Typical snacks (including when): N/A

How much do you drink of each of the following per day:

Water: 64 ounces (z)

Regular soda: ø ozz

Diet soda: ø ozz

Coffee or black/green tea: 16-20 ozz

Herbal tea: _____ ozz

Juice: _____ ozz

Alcohol: 8-12 ozz

Other _____: _____ oz

Follow up on any movement issues

still stiff

Explore exercise in more detail

Explore quality of nutrition – be sure ask about food AND drink

for vegans, vegetarians explore:

- ☐ protein sources
- ☐ b vitamin sources
- ☐ omega 3 sources

Note strengths movement to counter sedentary job

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PSYCHOLOGICAL and EMOTIONAL INFORMATION

How would you describe your **temperament** (e.g., introverted, extroverted, outgoing, sociable, loner, intense, easy going, etc.)? balanced introv./extrov., driven, socialable

Do you have any mental health **concerns, symptoms, or diagnoses**? Please describe (extra space on last page)

Have you received **mental health therapy or counseling**? Where, when, how long, how often?
No

Have you ever attempted or thought about suicide? Yes (No) — circled

Have you ever attempted or thought about harming someone else? Yes (No) — circled

Do you have a **history of mistreatment or abuse**? Yes (No) — circled
Please explain to the degree comfortable:

Please check the best answer for each of the following items for the **PAST 7 DAYS:**	*Never*	*Rarely*	*Sometimes*	*Often*	*Always*
I felt fearful	✓				
I found it hard to focus on anything other than my anxiety	✓				
My worries overwhelmed me	✓				
I felt uneasy	✓				
I felt worthless	✓				
I felt helpless	✓				
I felt depressed				✓	
I felt hopeless		✓			

Are you experiencing stress in any of the following areas?
Please check all that apply:

- ☐ Chronic pain / illness / health
- ☐ Caretaking a child or an elder
- ☐ Discrimination / Bias
- ☐ Divorce / Separation
- ☐ Economics / Money
- ☐ Family
- ☐ Grief / Death
- ☐ Identity
- ☐ Loss (e.g., job, home)
- ☐ Nutrition / Food
- ☐ Moving/Relocation
- ☐ Partner relationship
- ☐ School
- ☐ Sexuality / gender identity
- ☐ Sleep
- ☐ Substance use
- ☐ Traumatic event – nonpersonal
- ☐ Traumatic event – personal
- ☐ Work
- ☐ Other: ____________

How well are you able to **cope with** stress?

What do you typically do when stressed? exercise
drink wine
take walks

What do you do that helps you cope?
Soccer; long walks

What do you do that gets in the way?
drink wine

(Extra space on last page.)

CLINICIAN ONLY

Follow up on diagnoses symptoms including onset, frequency, duration, severity.

Assess duties (protect, warn, report)

Explore if mental health treatment has been received at PCH

From PROMIS-29 v2.0

Conduct Mini MSE
whole life (genetic)
Mood:
Affect:
Thought process:
Orientation * 3:
Other:

Follow up on all checked items
when not engaged in soccer or work, is "a blob"
Note strengths

SOCIAL, SOCIETAL, and SOCIOECONOMIC INFORMATION

CLINICIAN ONLY

What is your highest educational level?

- ☐ Less than high school
- ☐ High school / GED
- ☐ Some college no degree
- ☐ Associate degree
- ☐ Baccalaureate degree
- ☒ Masters degree
- ☐ Doctoral degree
- ☐ Other:

What was your degree major: ____

What is your current employment?

- ☐ Unemployed
- ☒ Employed – answer questions below:

Job title: Owner/Exec Dir.

Where: .

How long: 15+ years

Hours worked per day: 12

(Sedentary) or mobile:

How is your work-life balance?

Do you work too much? Not at all / somewhat / quite a bit / (a lot)

How much do you enjoy your work? Not at all / somewhat / quite a bit / (a lot)

How stressful is your work? Not at all / (somewhat) / quite a bit / a lot

Does work leave enough family time? Not at all / (somewhat) / quite a bit / a lot

Explore impact on physical and mental health

Self-care is not prioritized; "not present for the family or clients." M "[illegible] what she needs"

Describe your **social support network:** Do you have:

- ☒ Close friends; how many: 5-6
- ☒ Casual friends /social friendships
- ☒ Work / peer relationships
- ☒ Positive immediate family relationships
- ☒ Meaningful extended family relationships
- ☐ Community supports (e.g., via church, clubs)

Describe your **home environment:**

Do you rent or own? own

How many people live with you in your home: 2-3

What is the quality of your home? good

Describe your **neighborhood:** good

Have you ever experienced any of the following **socioeconomic challenges?**	Yes, at current	Yes, in the past	No, never
No income			✓
Poverty level income			✓
Homelessness			✓
Food insecurity			✓
Economic / financial deprivation			✓
Unsafe neighborhood			✓
Oppression because of your socioeconomic status			✓
Other:			

Follow up on any endorsed items (if none, inquire)

Have you ever experienced any of the following **sociopolitical or legal circumstances?**	Yes, at current	Yes, in the past	No, never
Immigration concerns			✓
Exposure to a polluted environment /toxins			✓
Engaged in political activism			✓
Engaged in criminal activity			✓
Been a victim of criminal activity			✓
Other:			

Note strengths

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CULTURAL and FAMILIAL INFORMATION

Please check the best answer for each of the following **cultural and family experiences** based on the present moment:	*Never*	*Rarely*	*Sometimes*	*Often*	*Always*
I feel a strong sense of cultural or community belonging based on common beliefs and values				✓	
I embrace important spiritual/religious beliefs, ethics, and morals				✓	
I feel strong emotional ties to a cultural or community group			✓		
I have experienced prejudice, bias, or oppression because of my cultural or community group memberships	✓				
I have experienced rejection, stigma, or ostracism	✓				
I experience intergenerationally transmitted / historical trauma	✓				
I experience strong emotional ties to a significant other					✓
I experience strong emotional ties to my immediate family					✓
I experience strong emotional ties to my extended family					✓
I experience conflict in some of my family relationships			✓		
My family holds strong shared values and beliefs					✓

* What are your most important life values?
live healthy

Where did you learn or develop these? self-taught (raised in a family of obese people)

What are your spiritual or religious beliefs?
do what is right

Where did you learn or develop these?

What is your most important community or cultural group?
soccer

How engaged in or isolated from this group are you?

What are your hobbies, interests, and typical recreational activities?
Soccer, reading

What do you like most about the community or cultural groups to which you belong?
playing soccer

What do you like most about your family?
unconditional love

What do you like most about yourself? good friend, good family; pays it forward; knowing when not to speak
? "hard to know" "blatantly honest" in a constructive way"

What else should we know about you?

CLINICIAN ONLY

Follow up on all endorsed items; if none, inquire

Explore family dynamics (relationships across generations, behavioral patterns, shared values, attachment styles)
parents passed (good role, not toxic); great marriage + kids

Explore family structure (stability, cohesiveness, divisiveness, closeness, distance, and boundaries)
1 sister good; 1 estranged
still in touch w/ aunts + uncles
- healthier to stay away from some family

Explore family communication styles

CLINICIAN ONLY – Behavioral Observations		CLINICIAN ONLY
Alignment (make notes as needed) ☐ Ears over shoulder ☐ Shoulders forward or backward ☐ Shoulders align over hips ☐ Upper back hunched (kyphosis) ☐ Shoulders collapsed ☐ Knee over ankles ☐ Ear over ankles ☐ Accentuated lower lumbar (lordosis) ☐ Feet straight ☐ Knees caps forward ☐ Hips rotation ☐ Pelvis anterior or posterior rotation ☐ Shoulders / clavicles even ☐ Hyperextension in joints	**Challenges Noted In** (make notes as needed): ☐ Balance ☐ Endurance ☑ Flexibility ☐ Gait ☐ Posture ☑ Strength **Strengths Noted In** (make notes as needed): ☑ Balance ☑ Endurance ☐ Flexibility ☐ Gait ☑ Posture ☐ Strength	Notes: need to view stability up; soccer is repetitive, needs to expand movements, body athl-

CLINICIAN ONLY – Information to Review with the Client

CLINICIAN ONLY

- ☑ The studio provides all necessary props, but you are welcome to bring your own mat.
- ☑ Discuss dates and times of the class (Ex: Mondays at 6pm, starting 10/30/2022)
- ☑ Emphasize that clients need to make an effort to be at all 10 sessions; it is a 10 week commitment. Ask clients to come 15-20 min early for the first session to fill out paperwork, and 5 min early before each class after that.
  - ☑ What would make it harder for you to attend the class? (i.e. Barriers): Fatigue
  - ☐ What would make it easier for you to attend the class? (i.e. Facilitators): ______
- ☑ Discuss format of the class: introductory talk/discussion about yoga philosophy, breathing practice, physical practice. Inform clients that while they are not required to participate in the discussion, it is going to be a regular component of the sessions.
- ☑ Voluntary adjustments are offered by the therapists; all hands-on work is very light and respectful. If you prefer not to be touched, please let us know. We can make verbal adjustments that do not require hands on your body. Adjustments are given in a spirit of support and offering a more healthful way- there is no wrong way to do yoga!
- ☑ Physical Adjustments? (Y/N): Y
- ☑ We will offer many modifications using props (e.g., blocks, straps); please be true to yourself and to your body. If something feels wrong, do NOT do it.
- ☑ Feel free to ask questions about anything we do either before, after, and/or during class
- ☑ Yoga is best practiced in comfortable clothes that will allow for stretching, as well as coverage throughout the class (e.g., clothes that do not slip).
- ☑ Yoga is best practiced on a relatively empty stomach, but not starving (a light snack prior to class will help you maintain your energy without being too full). Please refrain from eating heavy meals 2-3 hours before practice.
- ☑ Also, we ask that if you have any medical conditions that may affect your yoga practice, you let us know, so that we can help you with modifying poses for particular reasons.
- ☑ Please come a few minutes early to give yourself time to settle in on your mat.

Client: Blossoming Lotus MML 003

- ❑ There will be space in the corner of the room to store your personal belongings.
- ❑ Please turn off all cell phones before you settle in for class and remove any jewelry that may interfere with your practice.

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THIS SPACE IS LEFT FOR YOU TO SHARE MORE! Please add anything you'd like here. For example, explain about your pain, coping strategies, etc.

5/21/24 - Tuesday mornings - 8:30-10 am @ my house (6-10 sessions)
(7/23 - gone)
calendar invitations -

June - Changed to Saturday afternoons @ 1pm
2024

INTEGRAL YOGA
Client Release and Waiver of Liability Agreement

I, M L (Client), as a client of Irina Maria Massili "Tia Massili" (Trainee), hereby agree to the following:

RELEASE AND WAIVER OF LIABILITY

1. I am voluntarily participating in the Integral Yoga Therapy Practicum ("Practicum") which may involve physical, mental, emotional and spiritual wellness and Yoga practices offered by Tia Massili (Trainee). I am fully aware that Trainee is a student in training in the Integral Yoga Therapy Certification program, and at this time is NOT a Certified Yoga Therapist.

2. I recognize that I must be in good physical and mental health to participate in the Practicum. I understand that the Practicum may require physical exertion, and I represent and warrant that I am physically fit and I have no medical condition which would prevent my full participation in the Practicum. I understand that it is my responsibility to consult with a physician prior to and regarding my participation in the Practicum. If I have consulted a physician, I have taken the physician's advice. I understand that my trainee reserves the right in their absolute discretion to refuse my participation in the Practicum.

3. I agree to assume full responsibility for any risks, injuries or damages, known or unknown, which I might incur as a result of participating in the Practicum.

4. In further consideration of being permitted to participate in the Practicum, I knowingly, voluntarily and expressly waive any "Claim" (as defined below) I may have against my Trainee, Integral Yoga owners, members, employees, and/or its instructors, teachers, volunteer staff, interns, workshop presenters, independent contractors and the landlord of the Trainee (each, a "Released Party") for any Claim that I may sustain as a result of participating in the Practicum even if the Claim arises from the negligence of any Released Party or anyone else. I agree to indemnify and hold harmless each Released Party from any loss or liability incurred in defending any Claim made by me or any third party (including the employees and agents of the Trainee and its contractors) even if the Claim is alleged to or did result from the negligence of any Released Party. "Claim" includes but is not limited to any and all liabilities, claims, demands, expenses, fees (including attorneys' fees), legal actions, rights of actions for damages, personal injury, property damage, mental suffering and distress or death that I may suffer, my children or unborn child may suffer (including any legal fees or expenses) in connection with participation in any Practicum.

5. I, my heirs or legal representatives forever release, waive, discharge and covenant not to sue any Released Party for any Claim caused by any negligence or other acts of a Released Party.

6. This agreement shall be construed in accordance with, and governed by, the laws specific to the State I am receiving my training. I have carefully read this release and waiver of liability and fully understand its contents. I voluntarily and knowingly agree to the terms and conditions stated herein. I am aware that by signing this release and waiver of liability, I am giving up substantial rights that I or my heirs and assigns may have against any Released Party.

M L 3/28/21

M L