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Yoga Therapy Intake Packet

Please Note: This form supplements what you have provided on the Garden of Zen Yoga Studio Student Agreement of Release and Waiver of Liability. The yoga studio will be provided a copy of that form only, while any additional information provided on this form will be protected and only used in the yoga therapy process. The more information you provide, the more customized and effective your yoga therapy plan can be.

What are your current reason(s) for seeking yoga therapy? Do you have any specific goal(s)?

Depression, Anxiety, Exposing myself to new modalities of yoga, Better understanding of yoga

God

List your current and previous health conditions such as medical diagnoses, surgeries, accidents, illnesses, and injuries (include approximate date or how long ago for each).

N/A

Please list anyone else you are seeing for medical or general health concerns including alternative modalities such as doctors, specialists, massage, and acupuncture.

N/A

Please list your current medications, including over the counter and supplements.

N/A

Marijuana
Vape Nicotine

Please list any areas of the body you currently have or recently had discomfort, tension, or pain including anything that helps relieve it and rate each on a scale of 1 [very minor] to 10 [extremely painful or worrisome].

N/A

⊕ Neck
Occasional to
Aggravated by
dark work

Please list your favorite activities for both physical and mental health (i.e., walking the dog, yoga, swimming, listening to music or singing, gardening, coloring, crafts, puzzles) – including how frequently and how long per session.

N/A

Integral Yoga

What percentage of your typical day includes the following?

Sitting 70
Driving 20
Standing 10

Desk work
Lifting
Lying

Briefly describe your typical diet. How is your digestion (any gas or bloating)? How would you describe your bowel movements (frequency and consistency [normal, loose or constipated])?

Slightly fatty, bowel movements normally in the morning

How would you describe your sleep including length and how frequently you wake up?

6-7 hours nightly, undisturbed for the most part

What is your daytime energy level on a scale of 1 [ready for a nap] to 10 [Energizer bunny] – including right now, and the low and high if it fluctuates?

7

Please list any substance use including recreational or addictive such as tobacco products, coffee, alcohol, marijuana, narcotics or other pain killers, junk food, sexual activities, etc.

Vape, marijuana

Please describe any challenges in your life including stress, changes, sadness, anxiety, depression, etc.

stress, anxiety depression

Please describe any aspects in your life that bring you joy, happiness, pleasure, etc.

music, meditation, religious study

If you could change one thing in your life right now, what would it be?

Bank account

How much time per day and how many times per week would you like to devote to your yoga practice?

24 hours

Meditation & Pranayama

Please list any other information you would like to share or that might be helpful.

Leaving Relationship

Integral Life 1

Thank you for completing this intake form. It will be very helpful in working together to create a yoga therapy plan focused on your wants and needs.

*Swananda D.D

HW: 60 L2 Hatha MWF