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

BASIC PERSONAL INFORMATION			Clinician ONLY
Name: S[redacted], C[redacted] M		Date: 3-5-2025	Preferred Name:
Age: 63	Gender Identity: MALE	Who referred you? ☒ Self ☐ Clinician: _____ ☐ Other: _____	Preferred Pronouns:
What major concerns do you wish to address through Yoga: ☒ Physical: _____ ☐ Emotional: _____ ☐ Mental: _____ ☐ Spiritual: _____ ☐ Relationship: _____ ☐ Other: _____	What are your three main goals* for yoga therapy: BREATHING TECHNIQUES - PHYSICAL THERAPY - PULMONARY THERAPY	What is your intention** in seeking yoga therapy: MAINTAIN / IMPROVE OVERALL HEALTH	Notes:
YOGA PRACTICE BACKGROUND			Clinician ONLY
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: _____	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: _____ ☐ Meditation _____	Likes/dislikes related to practice?

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

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

Circle how often you engage in the following yoga practices:		Goals for practice
• 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*	

PHYSICAL HEALTH INFORMATION		CLINICIAN ONLY
Who is your primary care provider: Name: PASQUALE SANTINI Address: 5530 WISCONSIN AVE NW # 1400 CHEVY CHASE, MD 20815 Contact Information: (301) 656-9170	If you do not have a PCP, would you like us to make a referral: ☐ Yes, please ☐ No, thank you ☐ Ask me later	Make PCP referral OR Obtain release of information as needed

Are you struggling with any of the following:

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

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

- APPENDECTOMY
- HEEL RECONSTRUCTION
- SPINAL SURGERY

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

- SURGICAL - SEE ABOVE

When was your last (approximately):

- ☐ Physical exam: 3/2024
- ☐ Vision exam: 2019
- ☐ Dental check-up: 8/2024
- ☐ Hearing test: WHAT?
- ☐ Other:
- ☐ Other:

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

- ☑ HEEL 2012
- ☑ NECK/SPINE 2012
- ☒ BROKEN BONES - VARIOUS DATES

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

- ☑ OFEV
- ☑ TYVASO (TREPOSINIL)
- ☑ COLCHICINE - AS NEEDED
- ☑ VALIUM - AS NEEDED
- ☑ MUSCLE RELAXER - AS NEEDED

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

- ☒ MULTIVITAMINS

Follow up on all endorsed items

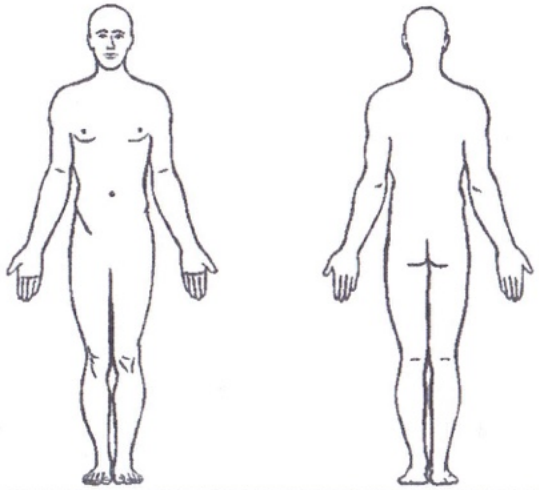
Ask about alcohol and smoking

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

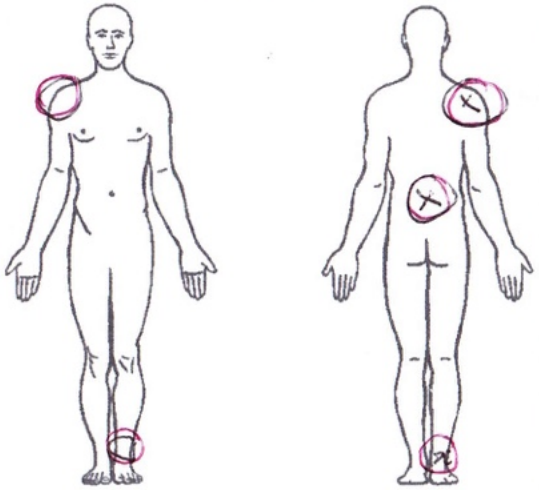
BACK ISSUES
LUNG DISEASE

Explore if movement aggravates or relieves

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: 0830 - 0900
Do you use an alarm to wake: yes (no)
Bedtime: 2300 - 2330
Do you fall asleep easily? (Yes) no
Hours of uninterrupted sleep per night? 4
Do you feel tired upon waking? (Yes) no

How much do you move every day?
How many hours do you sit each day (at work plus at home): 3-4 hours

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

What types of exercise do you do:
Type: WALK times per week: 4-5
number of minutes each time: 30 - 60

Type: STRETCHING times per week: 4-5
number of minutes each time: 30

Type: _____ times per week: _____
number of minutes each time: _____

How is your nutrition (food and drink)?
Typical breakfast: PROTEIN, DAIRY, FRUIT, BREAD

Typical lunch: PROTEIN, DAIRY, VEG,

Typical dinner: PROTEIN + 3 to 4 VEG

Typical snacks (including when): FRUIT, VEG, CHEESE VARIOUS

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 ozz
Herbal tea: Ø ozz
Juice: 12 ozz
Alcohol: 4 ozz
Other _____: _____oz

Explore quality of sleep:

- ☐ Initial insomnia
- ☐ Middle insomnia
- ☐ Terminal insomnia
- ☐ Night terrors, sleep walking
- ☐ Other sleep disturbance

Follow up on any movement issues

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

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Extra space on last page.

PSYCHOLOGICAL and EMOTIONAL INFORMATION	CLINICIAN ONLY
How would you describe your **temperament** (e.g., introverted, extroverted, outgoing, sociable, loner, intense, easy going, etc.)? SOCIABLE Do you have any mental health **concerns, symptoms, or diagnoses**? Please describe (extra space on last page) NO 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) Have you ever attempted or thought about harming someone else? (Yes) No Do you have a **history of mistreatment or abuse**? Yes (No) Please explain to the degree comfortable:	Follow up on diagnoses symptoms including onset, fre uency, duration, severity. Assess duties (protect, warn, report) Explore if mental health treatment has been received at PCH

Please check the best answer for each of the following items for the **PAST 7 DAYS:**	*Never*	*Rarely*	*Sometimes*	*Often*	*Always*	From PROMIS-29 v2.0
I felt fearful		X				Conduct Mini MSE
I found it hard to focus on anything other than my anxiety	X					
My worries overwhelmed me	X	X				Mood:
I felt uneasy		X				Affect:
I felt worthless	X					Thought process:
I felt helpless		X				Orientation * 3:
I felt depressed	X					Other:
I felt hopeless	X					

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

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

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

What do you typically do when stressed?
ADDRESS WHAT CREATED THE STRESS

What do you do that helps you cope?
TRY TO RESOLVE WHAT CAUSED THE STRESS

What do you do that gets in the way?

(Extra space on last page.)

Follow up on all checked items

Note strengths

SOCIAL, SOCIETAL, and SOCIOECONOMIC INFORMATION

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:

Where:

How long:

Hours worked per day:

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

CLINICIAN ONLY

Explore impact on physical and mental health

Describe your social support network: Do you have:
- ☒ Close friends; how many: _____
- ☒ 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)?
How many people live with you in your home: 1
What is the quality of your home? (LIKE?)
GOOD

Describe your neighborhood:
MIDDLE CLASS

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:			

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:			

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

Note strengths

CULTURAL and FAMILIAL INFORMATION						CLINICIAN ONLY
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				✓		Follow up on all endorsed items; if none, inquire
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		✓				Explore family dynamics (relationships across generations, behavioral patterns, shared values, attachment styles)
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				✓		Explore family structure (stability, cohesiveness, divisiveness, closeness, distance, and boundaries)
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? HONESTY	What are your spiritual or religious beliefs? ~~METHODIST~~	What is your most important community or cultural group? FRIENDS	Explore family communication styles
Where did you learn or develop these? CHILDHOOD	Where did you learn or develop these?	How engaged in or isolated from this group are you? AS ISOLATED OR ENGAGED AS I WANT TO BE	

What are your hobbies, interests, and typical recreational activities? COOKING, WALKING, SOCIAL ACTIVITIES	
What do you like most about the community or cultural groups to which you belong? ~~ROCKSIN~~	
What do you like most about your family? EVERYTHING	
What do you like most about yourself? EVERYTHING	
What else should we know about you?	

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:

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):_____
    _____
  - ❑ 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): _____
- ❑ 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.