Yoga THERAPY
INTAKE QUESTIONNAIRE

BASIC PERSONAL INFORMATION	
Name: [redacted]	**Today's Date:** 2ß24/11/02
Maiden Name (if applicable):	**Date of Birth:** 1966/08/26
Address: Lokstedter Steindamm 48 / 22529 Hamburg	
Preferred Phone: (home / work / cell) +49[redacted]	**May I leave a message at this number?** ◊ yes ◊ no
Alternative Phone: (home /work / cell)	**May I leave a message at this number?** ◊ yes ◊ no
Email: (please be aware that email may not be confidential) info@g-zaccaria.com	
How did you learn about our practice? by a friend	
Occupation: certified translator/interpreter MBA international marketing	**Employment Status** (full- or part-time, unemployed, retired, etc.): self-employed
Employer (if applicable):	
School (if applicable):	
Year in School and Program of Study (if applicable):	

croissant

Emergency Contact (and responsible person if you are under 18):

Name:

Relationship to you:

Address:

Phone:

Military Experience? ◊ yes ◊ no

Branch: MOS:

Years of Service: Combat exposure: ◊ yes ◊ no

Rank at Discharge: Type of discharge:

Racial and Ethnic Background:
caucasian

Sexual Orientation:
heterosexual

Spiritual and/or Religious Background:
catholic

Gender Identity and Your Pronouns:

History of Pregnancy and Labor:

Other important information about your background or values:

one pregnancy / caesarean section

Children: 0ne

Name(s)	Age(s)	Living with you (Yes/No)?
19 years old		

MEDICAL HISTORY

How would you describe your current physical health (e.g., poor, okay, good, excellent):

poor

Please describe any significant past medical problems and treatments (e.g., surgeries, problems in any of the following systems - immune, metabolic, respiratory, kidney and urinary, gastrointestinal, digestive, cardiovascular, nervous, muscle/bone/joint, reproductive):
diagnosis of multiple sclerosis in 2022/08

trigeminal nerve pain

Current Primary Care Physician's Name, Address, and Phone:

Do you wish to have your primary care physician contacted or involved in your mental health treatment?

◊ yes ◊ no

Please list any psychiatric and non-psychiatric medications you are currently taking:

Medication	Dosage	Reason for taking
only homeopathic medication		

Do you currently have a psychiatrist? ◊ yes ◊ no
If yes, please list name and contact info:

Have you been prescribed psychiatric medications in the past? ◊ yes ◊ no
If yes, please list medications:

Has anyone in your family had significant medical or psychiatric illnesses? ◊ yes ◊ no

If yes, please describe:

Please describe any past experience with outpatient therapy:

Therapist Start/End Dates Type of Treatment Reasons for Seeking Treatment

acupuncture

Please describe any past experience in inpatient or day hospital programs:

Facility/Program Start/End Dates Type of Program Reasons for Seeking Treatment

diagnosis of multiple sclerosis was established in hospital from 2024/08/16 - 2024/08/22 three months I was infected by corona virus .

Substance Use History

How often and how much do you drink alcohol?

no alcohol

Do you believe your alcohol use may be a problem? ◊ yes ◊ no

Do you believe you ever had a problem with alcohol use in the past? ◊ yes ◊ no

If so, please describe:

How often and how much do you use non-prescribed drugs?

almost never (Ibuprofen)

Do you believe your drug use may be a problem? ◊ yes ◊ no

Do you believe you ever had a problem with drug use in the past? ◊ yes ◊ no **If so, please describe:**
Do you struggle with other coping behaviors that feel addictive such as smoking, gambling, pornography, over-exercising, over- or under-eating, etc.? no!

Nutritional Summary

	Breakfast	Lunch	Dinner	Snacks
Average Time	8:00 -9:00 AM	12:00 AM - 2 PM	6 PM-8PM	seldom
Example of "best" snack/meal	porridge with fruits & nuts	vegetables	vegetables	fruits
Example of "worst" snack/meal	croissant with butter & marmelade	chips with sauces	pizza	potato chips

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Amount of daily water intake: 1,5 l - 3 l

Type/amount of intake of other fluids: herbal teas

Food cravings: sometimes chocolate

Food allergies/intolerances/sensitivities: none

Food preferences (circle all that apply): sweet sour salty bitter spicy salty

Do you prefer cooked foods or raw/cold foods? cooked

Eating schedule/habits (include snacks, etc):

Typical eating environment (at home, at work, sitting, standing, while driving, etc…): at home /sitting

How often do you prepare your own food? always

Frequency of consumption (how many servings/week)

7-20	coffee/caffeinated tea	O	soda
0	alcoholic beverages	4	sweets
3	eating out	7-20	fresh fruits/vegetables
10-20	animal protein	0	soy products
7	dairy	5	gluten

Stress

How do you typically handle stress? I try to relax / sit down or lay down / I use breathe technics

Do you have a relaxation and/or meditation program? If so, please describe type and frequency. autogenic training

Specific stressors right now: my pain attacks

Favorite time of the day: late morning Of year: summer time

Favorite type of weather: sunny & hot

Exercise frequency, type, and duration:

Sleep:

	Bedtime	Wake Time
Weekday	11 PM	8 - 9 AM
Weekend	11 - 12 PM	9-10 AM

3 d/w	Sleep less than 6 hours/night	1	Sleep more than 8 hours/night
1/2 h	Bedtime routine	1h	Lying in bed waiting to sleep (how long?)
3d/w	Disruptive midnight waking	3	Dreams

Emotional/Spiritual/Social health:

What are the predominant emotions in your life (circle all that apply)?

compassion	anger	rage	joy	nostalgia	love	grief
jealousy	sadness	worry	excitement	inspiration	fear	
anticipation	anxiety	emptiness	regret	apathy		

other:

How are your relationships . . .

With family:

With friends:

With your partner:

With your community:

Do you have a network for support you can call on?

What do you do for fun? What do you do to relax?

What in your life gives you a feeling of fulfillment?

I always wanted to be _____

I always wanted to do _____

Do you have a spiritual practice? What does it look like and what is its impact in your life?

Other Symptoms

Below is a list of behaviors and issues that are cause for concern for some people. Please mark any and all items that you think might apply to you. At the end of the list there is space to write any additional issues or concerns you might have.

o Aggression/violence	o Marijuana	o Issues from childhood
o Physical abuse	o Cocaine	o Hyperactivity

o Sexual abuse	o Prescription drugs	o Confusion
o Domestic violence	o Other illicit substances	o Sadness/Depression
o Anxiety/panic	o Restlessness	o Crying spells
o Sexual functioning difficulties	o Negativity	o Adultery/infidelity
o Parenting issues	o Difficulty forgiving	o Feeling empty/dissatisfied
o Suicidal thoughts/ gestures	o Nightmares	o Feeling like a failure
o Marital problems	o Unemployment	o Body image
o Relationship problems	o Feeling tired/fatigued	o Gambling
o Compulsive behaviors (handwashing, checking, etc.)	o Self-injury (cutting, burning, scratching, pulling out hair)	o Phobias (germs, heights, confined places, etc.)
o Financial problems	o Easily distracted	o Loss/grief due to death
o Career-related problems	o Anger	o Impulsiveness
o Homicidal thoughts/ gestures	o Hopelessness	o Difficulty at work
o Feeling spacey/detached from one's surroundings	o Partner/loved one's substance abuse	o Housework/home maintenance
o Loss of appetite	o Guilt	o Feelings of inferiority
o Sleep difficulty	o Obsessive thoughts/fears	o Trouble taking responsibility
o Attention/concentration	o Chronic headache	o Self-control
o Overeating	o Difficulty making decisions	o Lack of motivation
o Weight gain/loss	o Poor judgment	o Children with special needs (e.g., disabilities, medical conditions, behavioral problems)
o Eating disorder	o Procrastination	o Perfectionism
o Excessive worry	o Irritability	o Religion/spirituality
o Difficulty trusting others	o Trouble with authority	o Bad temper
o Low self-esteem	o Mood swings	o Separation/divorce
o Physical pain/discomfort	o Difficulty accepting/making changes	o Legal problems/court involvement
o Menstrual problems, PMS, menopause	o Overly concerned about what other people think	o Frequent conflicts with others
o Issues with elder parents	o Overly sensitive	o Cruelty/neglect of pets

o Lack of joy/satisfaction in life	o Hallucinations	o Alcohol
o Social withdrawal/ isolation	o Medical issues	o Smoking
o Stress	o Risky/dangerous behavior	o Feeling disorganized
o Loneliness	o Few friends	o Identity issues
o Problems with employer/ co-worker/employee	o Inappropriate/ uncomfortable sexual thoughts/urges	o Crises of faith
o Complications or trauma during labor and/or delivery	o Complications or trauma during labor and/or delivery	
o Loss during pregnancy		

Other Problems:

TREATMENT GOALS

Please take a moment to review the issues you noted above. Which three items concern you the most? In other words, which three concerns would you most like to have addressed in your treatment? By the end of treatment, what would you like to be different?

1.

2.

3.

OTHER

Please describe anything else that is important to know in understanding your life and your difficulties.

Thank you so much for completing this Intake Questionnaire.
It will be very helpful in developing an organized and effective treatment plan.
Please let us know if you have any questions. We look forward to working with you!