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 informationisabsolutely confidential. It is forprofessional use only.

Many thanks, Joy
Joy Sciabica joy@lightoflightyoga.com

Fu[redacted] Age 62 Personal Pronouns female Date 4/23/24

Email address [redacted]

Phone number: cell [redacted] other N/A

Occupation (previous if retired) Financial Administrator

Emergency contact: Name [redacted] Phone number: [redacted]

Yoga

What motivated you to beginyoga therapy at this time?

Many life stressors, want to be able to age w/ flexibility + balance

Are there any particularbenefits 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 stress/anxiety
Improve flexibility

Have you practiced yoga before? (Yes) No
Do you currently practice yoga? Yes (No) But I do some poses in stretching routine

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

None

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
If yes, please describe. Such as activities, frequency, self-directed or guided, duration, intensity.

Try to walk at least 3 days/week 45 min approx. 3mi
Stretching routine almost daily – given by PT 30 min.

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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.

I have been more mindful of movements and that helps.

Daily Routine

Do you have a typical waking routine? (Yes) No

Do you have a typical preparation for sleep routine? (Yes) No – Lately have been falling asleep on couch

Do you have a typical mealtime schedule? (Yes) No

Sleep

How many hours do you usually sleep each night? 6-7 usually in 2 chunks

On average, what time do you go to sleep and wake up? Sleep time 10:00 pm Wake time 5:00 – 6:00 am

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?

I think anxiety/worry.

Do you typically wake up feeling refreshed? Yes (No)

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 describeyour goals in this area.

Recently met w/ nutritionist. Already doing much of what she recommends. Just altering snacks + delivery of them. Prebagging nuts – example

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? Morning to early afternoon When are you least energized? evening

Stress

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

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

Are there any specific life circumstances contributing to your stress level now? (Yes) No

If yes, you are welcome to describe your primary stressors.

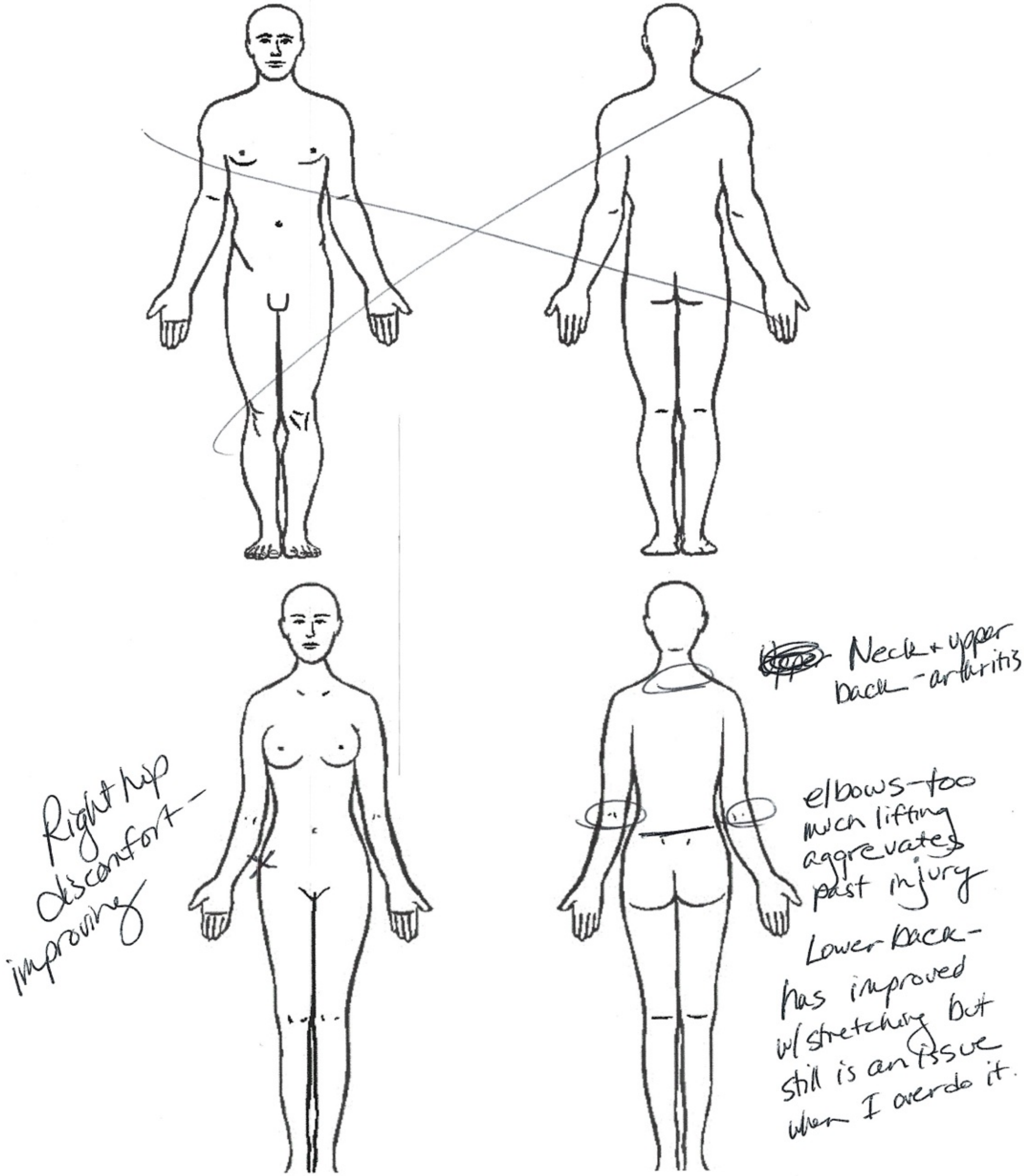
New grandson, daughter struggling w/ post partum issues, mother diagnosed w/ cancer, missing friends/support people from old town

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

Pray, read, walk, talk w/ friends, research solutions to stress issues, i.e. cancer treatments for mother

Physical and Mental Health ~~~~~~

Health conditions. You may describe areas of pain, numbness, or discomfort here:



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 - not currently
Chronic Pain	Heart disease	Seizures but have had
Circulatory issues, swelling	High blood pressure	Stroke
Depression	Insomnia, sleep issues	Thyroid condition(s)
Diabetes	Joint pain	Urinary condition(s)
Digestive/gastrointestinal illness	Memory issues	Weight concerns
Difficulty concentrating/focusing	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.
Balance Center at Danville for vertigo
Physical Therapy for joint pain

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 helps back pain - short term
Massage same

Have you had any surgeries, major injuries, or hospitalizations? (Yes) No
If yes, please note when and briefly describe each.
Fertility surgery in my 20's
Urological surgery in my teens

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

Do you have a history of substance abuse/addiction? Yes (No)
Are you in recovery presently? Yes No N/A

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.
Alcohol - 1x/week

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.

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

Meclazine - prn dizziness
Fish oil, CoQ10, Daily vitamin

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?

Do you like to (read,) listen to audio books, and/or listen to podcasts? (Yes) No

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 — not as physically accessible as before

Do you have a pet? Yes (No)

Is loneliness a concern for you? Yes No

Spirituality and Mindfulness~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Do you have a spiritual practice?This could range from strong religious affiliationto experiencing the wonders ofthe natural world. (Yes) No

If yes, please briefly describe.

Catholic - attend church regularly

What aspects of your life are meaningful to you?

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.

Love to cook, go thrifting, work in the yard

Mindfulness and Meditation

Do you practice mindfulness or meditation? Yes No

If yes, please briefly describe.

Pray the rosary

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.

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

INTEGRAL YOGA
Client Release and Waiver of Liability Agreement

I, [redacted] (Client), as a client of Joy Sciabica (Intern), 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 Joy Sciabica (Intern). I am fully aware that the Intern is a student in training in the Integral Yoga Therapy Certification program, and at this time is NOT a Certified Yoga Therapist. I further understand that the Intern will be supervised by a Certified Yoga therapist during the time completing the Practicum..

2. I recognize that I am choosing to participate in the Practicum in my current state of physical, mental, and emotional health. I understand that the Practicum may require physical exertion, and I represent and warrant that I am able to clearly communicate my physical capabilities and limitations, and I have no reason 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 the Intern 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 the Intern, Integral Yoga owners, members, employees, and/or its instructors, teachers, volunteer staff, workshop presenters, independent contractors and the landlord of the Intern (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 Intern 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.

[redacted]

Sig[redacted]

Printed Name of Client

4/23/24

Date