STILL WATERS

THERAPEUTIC YOGA

Angela Matysiak
815 Delaware Ave SW
Washington, DC 20024
office@stillwatersyoga.org

Our work will be to identify and support your goals of enhancing your health and well-being through an array of Yoga-based practices. The practices may range from gentle postures, stretching, breathing, meditation, guided relaxation, affirmations, to healthy lifestyle choices. Depending on your interests we may also use visualization, journaling, movement, or other techniques to support your self-discovery, transformation and healing process.

In all cases, the work is client-centered, and you are a full participant in the journey. By providing the information on this Intake form you will help me to tailor services to meet your needs. If there are any other medical or life circumstances not included on this form that would impact our work together, please let me know so that we may adapt practices specifically for your situation.

The information you provide will help us to work more effectively with you. All information will be strictly confidential, and nothing will be shared with a third party unless mutually agreed upon.

YOGA THERAPY INTAKE FORM Date: 03/07/2024

BASIC PERSONAL INFORMATION
[redacted]
[redacted]

[redacted]

[redacted]

Semi-retired	55

Female she/her

[redacted]

Racial and/or Ethnic Identity: White

How important is this to include in your yoga therapy?
0 – 1 – 2 – 3 – 4 – 5 – 6 – 7– 8 – 9 – 10
Not at all 0 Must be included

What religious or cultural practices were you raised in? Catholic

How important is this to include in your yoga therapy?

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7– 8 – 9 – 10
Not at all 0 Must be included

INSTRUCTIONS FOR YOUR FIRST YOGA THERAPY CONSULTATION

Thank you for giving thoughtful consideration as you complete this New Client Questionnaire. You will have ample opportunity to address any concerns that require more detail during your appointment with your practitioner.

Please bring the completed New Client Questionnaire to your first visit

Please also bring a Yoga mat and wear comfortable clothing.

Client confidentiality will be observed under all circumstances.

If you do have any questions, please contact your practitioner:

PERSONAL HISTORY

For what issue, concern, or specific condition are your seeking yoga therapy?

Rheumatoid arthritis and degenerative disc disease

- How long have you had this?

11 years

On a scale of 0-10, please rate the amount of pain that you associate with your concern:

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7– 8 – 9 – 10 3-7

None worst ever

3-7

On a scale of 0-10, please rate the amount of stress that you associate with your concern: 3-5

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7– 8 – 9 – 10

None worst ever

Are you currently under the care of a doctor or other healthcare provider? Y/N
If yes, please identify the provider(s) and the condition(s) you are being treated for:

Y. National Pain & Spine Centers and Northern Virginia Center for Arthritis
Degenerative disc disease and autoimmune conditions

Please list any other relevant medical history (major injuries, hospitalizations, surgeries, chronic conditions, or limitations) not listed above: Neck and back surgery

Are you currently being seen by a mental health provider? If yes, please identify the provider and the condition you are being seen for: NO

Please list any prescription or non-prescription medication you are currently taking:

Medication	Reason for taking
Humira	_RA
Methotrexate	
Baclofen	Degenerative disc disease

What is your use of complementary and integrative health (CIH) – supplements, herbs, use of other CIH practitioners and healers? Vitamins C & B-12

Lifestyle and Wellness

Do you currently exercise? Y/N Y If yes, please describe your current program: yoga and walking

Are you familiar with Yoga? Y/N Y If yes, please describe your experience: I have been doing yoga off and on for about 20 years.

Do you have a relaxation and/or meditation program? If yes, please describe: No

Do you drink alcohol? Y/N Y If yes what's your typical pattern: one or two glasses of wine at night
Do you use tobacco products? Y/N N If yes, what's your typical pattern?
Do you use non-prescribed (illicit) drugs? Y/N N If yes, what's your typical pattern?
Do you struggle with other behaviors that feel addictive (gambling, porn, over-exercising, over- or under-eating, etc.)? N
What foods do you crave or eat when… -stressed: nothing in particular _____ -bored: Chips or popcorn or chew gum _____ -happy: Nothing in particular, maybe pizza _____
Do you feel your diet needs improvement? Y/N -If yes, how? Yes. I need to snack less and eat more fruits and vegetables.
How would you rate the quality of your sleep? OK Poor -- Fair -- Ok -- Good -- Great
Are there any other habits you would like to change? No

How is your overall energy level? Good Poor -- Fair -- Ok -- Good -- Great
What time of day do you typically feel most energized? Daytime. Late morning and/or early afternoon
What words best describe your breathing? (Please circle/ underline any that apply) Full, deep, easy, steady, slow, long, calming, even regular, sustaining Sharp, short, fast, loud, forced, irregular, tight, restricting Shallow, silent, unfulfilling, flat, empty, weak, depleting Other(s): Steady
Do you have any breathing challenges not mentioned above? Y/N If yes, please explain: Sometimes I get short of breath climbing stairs.
What is your current level of stress? 3 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7– 8 – 9 – 10 No stress at all 3 Couldn't be more stressed
What tends to bring on or trigger stress in your life? Disagreements with people/getting along with others sometimes.
How do you typically handle stress? Just try and deal with things using a level head or dealing with a situation at a later date.

What are the predominant emotions in your life? (Please circle/ underline all that apply) Joyful

Absent Despairing Exhausted Hopeless Numb Overwhelmed Terrified Unloved Without Alarmed Envious Frightened Judgmental Overdoing Pressured Troubled Unwanted Worried Free Grateful Happy Joyful Kind Loving Playful Relaxed Trusting Whole

Other(s):

Have you experienced a life-threatening event, serious injury or sexual violence…

- Directed at yourself No Y / N
- Witnessed happening in person to someone else Yes Y / N
- Learned it happened to a close family member or loved one Yes Y / N
- Repeatedly heard details in an occupational role (ER tech, police, etc.) No Y / N

Who makes up your social support system? (e.g., family, friends, health professionals, support groups, etc.) family, friends, cats

How would you describe the quality of your social support? Do you have someone to call in on in case of an emergency at 3 AM? Yes

What in your life gives you meaning and purpose?
My cats, being in nature, spending time with family and friends

What do you like to do for fun? Spending time with my cats, going to Starbucks, being out in nature, movies, dabbling in languages, watching the news, doing brain teasers, yoga, walking, traveling, being with my sister and son, going to the beach

Do you have a spiritual practice? Y/N No. If yes, how would you describe the spiritual dimension of your life?
What, if anything, should I know about your belief system or worldview? I am generally a happy person.
What do you hope to get out of a yoga therapy session? What are your main goals? Just to feel better overall physically and mentally and to loosen tight muscles and strengthen my entire body.
Is there anything else you'd like me to know before we start our work? You are a wonderful yoga instructor !

Thank you for completing this Intake Questionnaire.