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

1/16/24

| BASIC PERSONAL INFORMATION | | | Clinician ONLY |
|---|---|---|---|
| Name: 001 PAM | | Date: | Preferred Name: |
| Age: 72 | Gender Identity: F | Who referred you?<br>☑ Self<br>☐ Clinician: _____<br>☐ Other: _____ | Preferred Pronouns: |
| What major concerns do you wish to address through Yoga:<br>☑ Physical: _____<br>☐ Emotional: _____<br>☐ Mental: _____<br>☐ Spiritual: _____<br>☐ Relationship: _____<br>☐ Other: _____ | What are your three main goals* for yoga therapy:<br>1. less/no pain<br>2. strength<br>3. flexibility | What is your intention** in seeking yoga therapy:<br>better quality of life | Notes: |

| YOGA PRACTICE BACKGROUND | | | Clinician ONLY |
|---|---|---|---|
| How long have you practiced?<br>☐ No experience – 0 years<br>☑ < 1 year<br>☑ 1-3 years<br>☐ 4-5 years<br>☐ 6-10 years<br>☐ >10 years | How often do you practice?<br>☐ Not applicable (N/A)<br>☐ < 1x per week<br>☐ 1-2x per week<br>☐ 3-4x per week<br>☐ >5x per week<br>☑ Other: varies | How long is each session on average?<br>☐ N/A<br>☑ 15-30 minutes<br>☑ 31 to 45 minutes personal group<br>☐ 46 to 60 minutes<br>☐ 61 to 90 minutes<br>☐ Other: _____ | Notes: |
| What is your favorite kind of yoga?<br>☐ Chair<br>☑ Gentle<br>☐ Power<br>☐ Other/N/A: _____ | Where do you practice most?<br>☐ Yoga studio<br>☐ Fitness/Rec Center<br>☑ Home on my own<br>☐ Online<br>☐ Other/N/A: _____ | Do you have other mind-body practices? e.g.,:<br>☐ Martial Arts<br>☐ Tai Qi<br>☐ Other/N/A: _____<br>☑ 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.



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Client: PAM

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Circle how often you engage in the following yoga practices:

| | | | |
|---|---|---|---|
| • 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 |

Goals for practice

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– due to inability to walk @ this time

**PHYSICAL HEALTH INFORMATION**

Who is your primary care provider: N/A
Name:
Address:
Contact Information:

If you do not have a PCP, would you like us to make a referral:
- ☐ Yes, please
- ☐ No, thank you N/A
- ☐ Ask me later

CLINICIAN ONLY

Make PCP referral OR
Obtain release of information as needed

in the process of switching PCP

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Client: 001 PNA

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Are you struggling with any of the following:

- [ ] Addiction / alcohol / drugs
- [ ] Adrenal fatigue / illness
- [ ] Allergies
- [x] Anxiety has it
- [x] Arthritis
- [?] Autoimmune disease maybe
- [ ] Cancer
- [x] Chronic Pain
- [ ] Dementia
- [ ] Depression
- [x] Diabetes (maybe pre-diabetic)
- [x] Digestive/gastrointestinal ~~illness~~ issues
- [ ] Eating disorder / anorexia / bulimia
- [ ] Head injury
- [ ] Heart disease
- [x] High blood pressure controlled
- [x] High cholesterol —"—
- [ ] HIV/AIDS
- [ ] Kidney disease
- [ ] Liver disease / hepatitis
- [ ] Lung disease / Asthma / COPD
- [ ] Menopause
- [x] Musculoskeletal concern
- [ ] Movement Disorder
- [ ] Neurological disease
- [x] Osteoporosis
- [ ] Schizophrenia
- [x] Sciatica ?
- [ ] Skin problems
- [x] Sleep problems
- [ ] Stroke
- [ ] Thyroid issues
- [ ] Vision problems / eye disease
- [x] Weight concerns
- [ ] Other: _____

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

lumpectomy on L breast

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

01 nites

When was your last (approximately):

- [x] Physical exam: 1yr.
- [x] Vision exam: 1yr.
- [x] Dental check-up: 6 mos.
- [x] Hearing test: 2yrs.
- [x] Other: Spinal (MRI)
- [ ] Other: "Pain Doctor"

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

- [x] 4 car collisions (3 from backend)
- [ ] may have affected neck
- [ ]
- [ ]
- [ ]

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

- [x] Celebrex
- [x] Statin
- [x] Mupirocin
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]

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

- [x] N/A
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]

Follow up on all endorsed items

Ask about alcohol and smoking

lumbar stenosis

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

In pain, + as a result don't move as much as we'd like to; affects sleep, don't sleep long hours."

Explore if movement aggravates or relieves

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Client: 001 PRM

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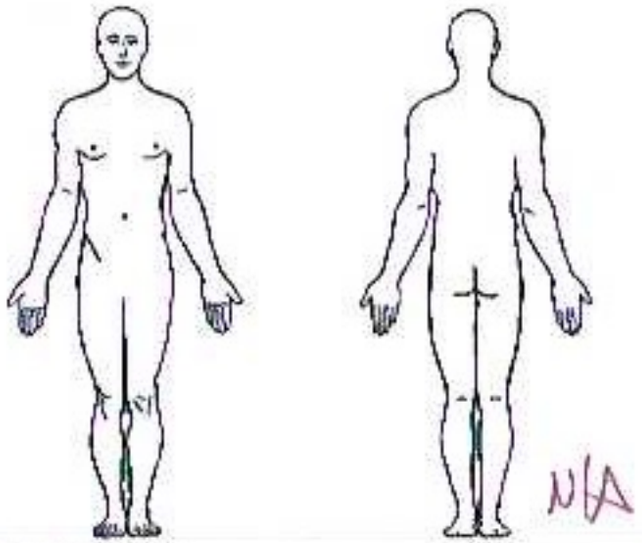
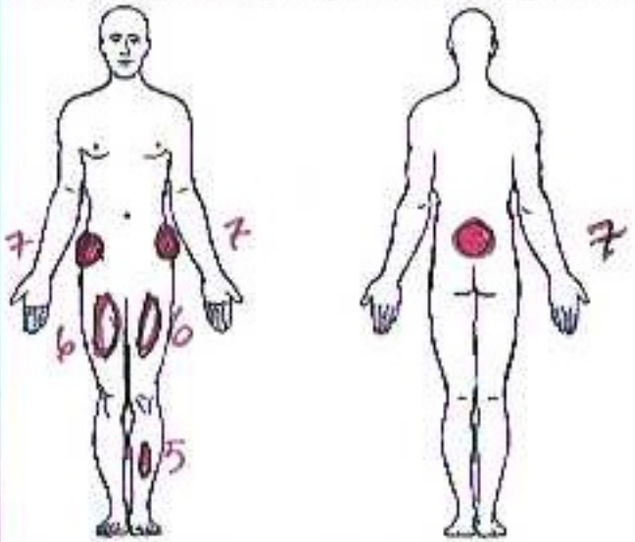
**Please mark where you currently experience ACUTE pain**




**Please mark where you experience CHRONIC pain ***




Ask for pain rating from 1 to 10 for each indicated area:

DDuke is narrowing (MRI)
holes where nerves travel are narrowing = Osteophyte

Explore if movement aggravates or relieves:

laying down – aggravates
epsom salts } relieves
ice
massage

**How is your sleep?**

Wake-up time: 6 am
Do you use an alarm to wake: yes (no)
Bedtime: 10 pm
Do you fall asleep easily? (Yes) no
Hours of uninterrupted sleep per night? 2-3 hrs.
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): too many hours

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

What types of exercise do you do: None
Type: PT / stretching times per week: daily
number of minutes each time: 20

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

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

**How is your nutrition** (food and drink)?

Typical breakfast: eggs w/ ham, toast, veggies

Typical lunch: leftovers (soup, stir-fry, meatballs)

Typical dinner: protein + veggies

Typical snacks (including when): evening – nuts, pretzels

How much do you drink of each of the following per day:

Water: 8 x 4 32 ounces (z)
Regular soda: _____ ozz
Diet soda: _____ ozz
Coffee or black/green tea: 2 cups ozz
Herbal tea: _____ ozz
Juice: _____ ozz
Alcohol: _____ ozz
Other _____: _____ oz

no more soda consumption (heavy soda drinker in the past)

Explore quality of sleep:

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

Follow up on any movement issues

dropping things more than usual, is more aware of this

Explore exercise in more detail: None

Explore quality of nutrition – be sure ask about food AND drink

for vegans, vegetarians explore:

- protein sources
- b vitamin sources
- omega 3 sources needs more – supplementation

**Note strengths**

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Client: 601 PAM

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1/16/24

## PSYCHOLOGICAL and EMOTIONAL INFORMATION

How would you describe your **temperament** (e.g., introverted, extroverted, outgoing, sociable, loner, intense, easy going, etc.)?

Do you have any mental health **concerns, symptoms, or diagnoses?** Please describe (extra space on last page)

MA

Have you received **mental health therapy or counseling**? Where, when, how long, how often? Yes; years (since 1980s?) on-going wkly over last 7 years

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:

## CLINICIAN ONLY

Follow up on diagnoses symptoms including onset, frequency, duration, severity.

Assess duties (protect, warn, report)

N/A

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* |
|---|---|---|---|---|---|
| I felt fearful | ✓ | | | | |
| I found it hard to focus on anything other than my anxiety | ✓ | | | | |
| My worries overwhelmed me | ✓ | | | | |
| I felt uneasy | ✓ | ✓ | | | |
| I felt worthless | ✓ | | | | |
| I felt helpless | ✓ | | | | |
| I felt depressed | | ✓ | | | |
| I felt hopeless | ✓ | | | | |

From PROMIS-29 v2.0
unless were talking (removed - hopeless)

Conduct Mini MSE

Mood:
Affect:
Thought process:
Orientation * 3:
Other:

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

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

How well are you able to **cope with stress**? not great at it, but not crazy

What do you typically do when stressed? Look @ worst case scenario +

What do you do that helps you cope? avoid it; play solitaire

What do you do that gets in the way? nothing

(Extra space on last page.)

Follow up on all checked items ✓
Worrier, more than she "should".

**Note strengths**:
- kind, smart, bright - has
- therapeutic methods to deal w/ stress

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by others; & call to deep empathy

**SOCIAL, SOCIETAL, and SOCIOECONOMIC INFORMATION** | CLINICIAN ONLY

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 ☐ Retired
- ☐ Employed – answer questions below:

Job title: Retired teacher

Where:

How long:

Hours worked per day:

Sedentary or mobile:

How is your **work-life balance?** N/A

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: 3
- ☐ 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? lovely Precious

Describe your **neighborhood:** upper middle class; somewhat rural due to homelyards but not far from main road

| 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 :**

Client: PAM

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4/6/24

## CULTURAL and FAMILIAL INFORMATION

| 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 | | | | ✓ | |
| 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 | ✓ | | | | |
| 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 | | | | | ✓ |
| 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? fairness, compassion,

Where did you learn or develop these? my mom

What are your spiritual ~~or religious~~ beliefs? order in the universe, as well as disorder; a higher power, not necessarily ~~an~~ entity

Where did you learn or develop these? on my own through reading; from my family

What is your most important community or cultural group? "old hippies"

How engaged in or isolated from this group are you? only people I know

What are your hobbies, interests, and typical recreational activities?

reading, movies, painting, cooking, making things, theatre

What do you like most about the community or cultural groups to which you belong?

My values are shared by those people; I'm lucky to live where I live.

What do you like most about your family? not parochial; we have a world view; are interesting; look beyond ourselves; we have fun together

What do you like most about yourself? learned to be easy-going

What else should we know about you? I have made significant strides in understanding myself, understanding others; finding contentment over the last decade.

### CLINICIAN ONLY

Follow up on all endorsed items; if none, inquire

Explore family dynamics (relationships across generations, behavioral patterns, shared values, attachment styles)

Explore family structure (stability, cohesiveness, divisiveness, closeness, distance, and boundaries)

altered to think outside the box

Explore family communication styles

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Client: Blossoming Lotus 1/16/24

## CLINICIAN ONLY – Behavioral Observations

**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 – not as much as before
- ☑ Endurance
- ☑ Flexibility
- ☑ Gait
- ☑ Posture
- ☑ Strength

**Strengths Noted In** (make notes as needed):
- ❑ Balance
- ❑ Endurance
- ❑ Flexibility
- ❑ Gait
- ❑ Posture
- ❑ Strength

CLINICIAN ONLY

Notes:
min. 5–10, 3x/day

PT exercises:
- US windshield wipers
- leaning forward (elongated spain) (rocking out)
- standing + leaning forward
-

pool: 1x/wk
mini-meditations
- list of minimal activities you commit to; + any type of exercise I can do

## 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) 12 sessions would end on my b' day
- ❑ 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):_____ Sutra 1.14 meditation, diet
- ❑ 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.

- ❑ There will be space in the corner of the room to store your personal belongings.
- ❑ Please turn off all cell phones before you settle in for class and remove any jewelry that may interfere with your practice.

***THIS SPACE IS LEFT FOR YOU TO SHARE MORE!*** Please add anything you'd like here. For example, explain about your pain, coping strategies, etc.

Client: 001 PRM

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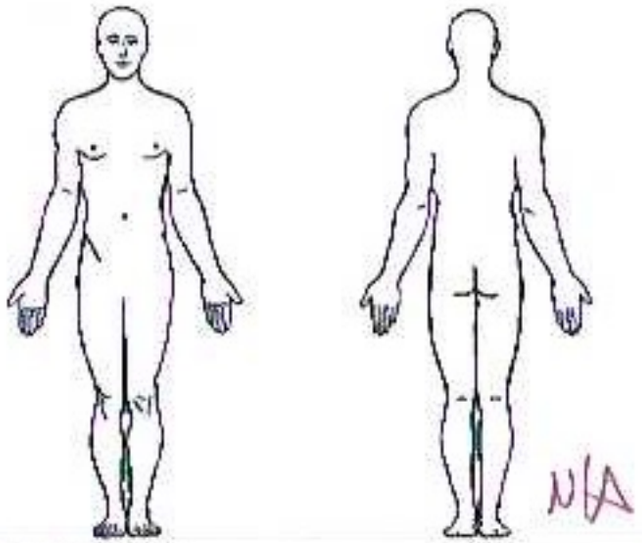
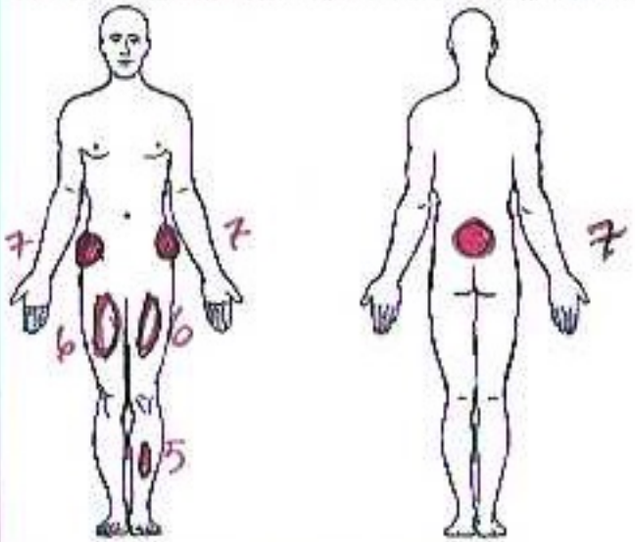
**Please mark where you currently experience ACUTE pain**




**Please mark where you experience CHRONIC pain ***




Ask for pain rating from 1 to 10 for each indicated area:

DDuke is narrowing (MRI)
holes where nerves travel are narrowing = Osteophyte

Explore if movement aggravates or relieves:

laying down – aggravates
epsom salts } relieves
ice
massage

**How is your sleep?**

Wake-up time: 6 am
Do you use an alarm to wake: yes (no)
Bedtime: 10 pm
Do you fall asleep easily? (Yes) no
Hours of uninterrupted sleep per night? 2-3 hrs.
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): too many hours

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

What types of exercise do you do: None
Type: PT / stretching times per week: daily
number of minutes each time: 20

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

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

**How is your nutrition** (food and drink)?

Typical breakfast: eggs w/ ham, toast, veggies

Typical lunch: leftovers (soup, stir-fry, meatballs)

Typical dinner: protein + veggies

Typical snacks (including when): evening – nuts, pretzels

How much do you drink of each of the following per day:

Water: 8 x 4 32 ounces (z)
Regular soda: _____ ozz
Diet soda: _____ ozz
Coffee or black/green tea: 2 cups ozz
Herbal tea: _____ ozz
Juice: _____ ozz
Alcohol: _____ ozz
Other _____: _____ oz

no more soda consumption (heavy soda drinker in the past)

Explore quality of sleep:

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

Follow up on any movement issues

dropping things more than usual, is more aware of this

Explore exercise in more detail: None

Explore quality of nutrition – be sure ask about food AND drink

for vegans, vegetarians explore:

- protein sources
- b vitamin sources
- omega 3 sources needs more – supplementation

**Note strengths**

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1/16/24

| BASIC PERSONAL INFORMATION | | | Clinician ONLY |
|---|---|---|---|
| Name: 001 PAM | | Date: | Preferred Name: |
| Age: 72 | Gender Identity: F | Who referred you?<br>☑ Self<br>☐ Clinician: _____<br>☐ Other: _____ | Preferred Pronouns: |
| What major concerns do you wish to address through Yoga:<br>☑ Physical: _____<br>☐ Emotional: _____<br>☐ Mental: _____<br>☐ Spiritual: _____<br>☐ Relationship: _____<br>☐ Other: _____ | What are your three main goals* for yoga therapy:<br>1. less/no pain<br>2. strength<br>3. flexibility | What is your intention** in seeking yoga therapy:<br>better quality of life | Notes: |

| YOGA PRACTICE BACKGROUND | | | Clinician ONLY |
|---|---|---|---|
| How long have you practiced?<br>☐ No experience – 0 years<br>☑ < 1 year<br>☑ 1-3 years<br>☐ 4-5 years<br>☐ 6-10 years<br>☐ >10 years | How often do you practice?<br>☐ Not applicable (N/A)<br>☐ < 1x per week<br>☐ 1-2x per week<br>☐ 3-4x per week<br>☐ >5x per week<br>☑ Other: varies | How long is each session on average?<br>☐ N/A<br>☑ 15-30 minutes<br>☑ 31 to 45 minutes personal group<br>☐ 46 to 60 minutes<br>☐ 61 to 90 minutes<br>☐ Other: _____ | Notes: |
| What is your favorite kind of yoga?<br>☐ Chair<br>☑ Gentle<br>☐ Power<br>☐ Other/N/A: _____ | Where do you practice most?<br>☐ Yoga studio<br>☐ Fitness/Rec Center<br>☑ Home on my own<br>☐ Online<br>☐ Other/N/A: _____ | Do you have other mind-body practices? e.g.,:<br>☐ Martial Arts<br>☐ Tai Qi<br>☐ Other/N/A: _____<br>☑ 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.



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Client: Blossoming Lotus 1/16/24

## CLINICIAN ONLY – Behavioral Observations

**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 – not as much as before
- ☑ Endurance
- ☑ Flexibility
- ☑ Gait
- ☑ Posture
- ☑ Strength

**Strengths Noted In** (make notes as needed):
- ❑ Balance
- ❑ Endurance
- ❑ Flexibility
- ❑ Gait
- ❑ Posture
- ❑ Strength

CLINICIAN ONLY

Notes:
min. 5–10, 3x/day

PT exercises:
- US windshield wipers
- leaning forward (elongated spain) (rocking out)
- standing + leaning forward
-

pool: 1x/wk
mini-meditations
- list of minimal activities you commit to; + any type of exercise I can do

## 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) 12 sessions would end on my b' day
- ❑ 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. Sutra 1.14 meditation, diet
- ❑ 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.

Client: PAM

Blossoming Lotus

1/6/24

Circle how often you engage in the following yoga practices:

| | | | |
|---|---|---|---|
| • 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 |

Goals for practice

Blossoming Lotus

- due to inability to walk @ this time

**PHYSICAL HEALTH INFORMATION**

Who is your primary care provider: N/A
Name:
Address:
Contact Information:

If you do not have a PCP, would you like us to make a referral: N/A
- ☐ Yes, please
- ☐ No, thank you
- ☐ Ask me later

CLINICIAN ONLY

Make PCP referral OR
Obtain release of information as needed

- in the process of switching PCP

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Client: 001 PNA

Blossoming Lotus

1/16/24

Are you struggling with any of the following:

- Addiction / alcohol / drugs
- Adrenal fatigue / illness
- Allergies
- ✓ Anxiety has it
- ✓ Arthritis
- ? Autoimmune disease maybe
- Cancer
- ✓ Chronic Pain
- Dementia
- Depression
- ✓ Diabetes (maybe pre-diabetic)
- ✓ Digestive/gastrointestinal ~~illness~~ issues
- Eating disorder / anorexia / bulimia
- Head injury
- Heart disease
- ✓ High blood pressure controlled
- ✓ High cholesterol —"—
- HIV/AIDS
- Kidney disease
- Liver disease / hepatitis
- Lung disease / Asthma / COPD
- 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

Lumpectomy on L breast

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

6 wks

When was your last (approximately):

- ✓ Physical exam: 1yr.
- ✓ Vision exam: 1yr.
- ✓ Dental check-up: 6 mos.
- ✓ Hearing test: 2yrs.
- ✓ Other: Spinal (MRI)
- Other: "Pain Doctor"

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

- ✓ 4 car collisions (3 from backend)
- may have affected neck

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

- ✓ Celebrex
- ✓ Statin
- ✓ Mupirocin

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

- N/A

Follow up on all endorsed items

Ask about alcohol and smoking

lumbar stenosis

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

In pain, + as a result don't move as much as I'd like to; affects sleep, can't sleep long hours."

Explore if movement aggravates or relieves

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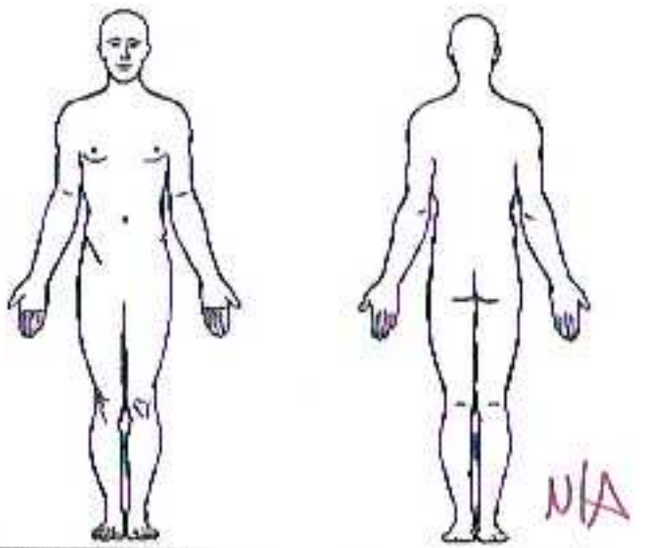
Client: 001 PAM

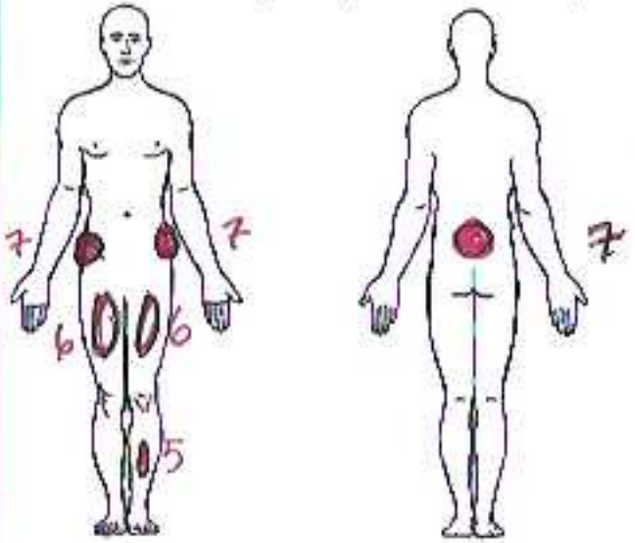
1/16/24

Blossoming Lotus

**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:

Spine is narrowing (MRI)
holes where nerves travel are narrowing = Osteophytes

Explore if movement aggravates or relieves:

laying down – aggravates & relieves
epsom salts
ice
massage

**How is your sleep?**

Wake-up time: 6 am
Do you use an alarm to wake: yes (no)
Bedtime: 10 pm
Do you fall asleep easily? (Yes) no
Hours of uninterrupted sleep per night? 2-3 hrs.
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): too many hours

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

What types of exercise do you do: None

Type: PT / stretching times per week: daily
number of minutes each time: 20

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

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

**How is your nutrition** (food and drink)?

Typical breakfast: eggs w/ ham, toast, veggies

Typical lunch: leftovers (soup, stir-fry, meatballs)

Typical dinner: protein + veggies

Typical snacks (including when): evening – nuts, pretzels

How much do you drink of each of the following per day:

Water: 8x4 32 ounces (z)
Regular soda: _____ ozz
Diet soda: _____ ozz
Coffee or black/green tea: 2 cups ozz
Herbal tea: _____ ozz
Juice: _____ ozz
Alcohol: _____ ozz
Other _____: _____ oz

no more soda consumption (heavy

Explore quality of sleep:

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

Follow up on any movement issues

dropping things more than usual, ↓ more aware of this

Explore exercise in more detail: None

Explore quality of nutrition – be sure ask about food AND drink

for vegans, vegetarians explore:

- protein sources
- b vitamin sources
- omega 3 sources needs more – anti-inflammation

**Note strengths**

soda drinker in the past

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Client: 601 PAM

Blossoming Lotus

1/16/24

## PSYCHOLOGICAL and EMOTIONAL INFORMATION

How would you describe your **temperament** (e.g., introverted, extroverted, outgoing, sociable, loner, intense, easy going, etc.)?

Do you have any mental health **concerns, symptoms, or diagnoses?** Please describe (extra space on last page)

MA

Have you received **mental health therapy or counseling**? Where, when, how long, how often? Yes; years (since 1980s?) on-going wkly over last 7 years

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:

| Please check the best answer for each of the following items for the **PAST 7 DAYS:** | *Never* | *Rarely* | *Sometimes* | *Often* | *Always* |
|---|---|---|---|---|---|
| I felt fearful | ✓ | | | | |
| I found it hard to focus on anything other than my anxiety | ✓ | | | | |
| My worries overwhelmed me | ✓ | | | | |
| I felt uneasy | ✓ | ✓ | | | |
| I felt worthless | ✓ | | | | |
| I felt helpless | ✓ | | | | |
| I felt depressed | | ✓ | | | |
| I felt hopeless | ✓ | | | | |

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

- ☐ Chronic pain / illness / health
- ☐ Caretaking a child or an elder
- ☐ Discrimination / Bias
- ☐ Divorce / Separation
- ☐ Economics / Money
- ☐ Family
- ☐ Grief / Death
- ☐ Identity
- ☐ Loss (e.g., job, home)
- ☐ Nutrition / Food
- ✓ ~~Moving/Relocation~~ Re-relocation
- ☐ Partner relationship
- ☐ School
- ☐ Sexuality / gender identity
- ☐ Sleep
- ☐ Substance use
- ☐ Traumatic event – nonpersonal
- ☐ Traumatic event – personal
- ☐ Work
- ✓ Other: Deep sadness deeply by others; & U call it deep empathy

How well are you able to cope with stress? not great at it, but not crazy

What do you typically do when stressed? Look @ worst case scenario +

What do you do that helps you cope? avoid it; play solitaire

What do you do that gets in the way? nothing

(Extra space on last page.)

## CLINICIAN ONLY

Follow up on diagnoses symptoms including onset, frequency, duration, severity.

Assess duties (protect, warn, report)

N/A

Explore if mental health treatment has been received at PCH

From PROMIS-29 v2.0 unless were talking (removed)

Conduct Mini MSE - hopeless!

Mood:
Affect:
Thought process:
Orientation * 3:
Other:

Follow up on all checked items ✓

Worrier, more than she "should".

**Note strengths**:

- Kind, smart, bright - has developed therapeutic methods to deal w/ stress

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## SOCIAL, SOCIETAL, and SOCIOECONOMIC INFORMATION

CLINICIAN ONLY

Explore impact on physical and mental health

**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 ☐ Retired
- ☐ Employed – answer questions below:

Job title: Retired teacher

Where:

How long:

Hours worked per day:

Sedentary or mobile:

**How is your work-life balance?** N/A

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

**Describe your social support network:** Do you have:

- ☑ Close friends; how many: 3
- ☐ 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? lovely Precious

**Describe your neighborhood:** upper middle class; somewhat rural due to homelyards but not far from main road

| 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 :**

Client: PAM

Blossoming Lotus

4/6/24

| 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 | | | ✓ | | | altered to think outside the box |
| My family holds strong shared values and beliefs | | | | ✓ | | |

What are your most important life values? fairness, compassion,

Where did you learn or develop these? my mom

What are your spiritual ~~or religious~~ beliefs? order in the universe, as well as disorder; a higher power, not necessarily an entity

Where did you learn or develop these? on my own through reading; from my family

What is your most important community or cultural group? "old hippies"

How engaged in or isolated from this group are you? only people I know

Explore family communication styles

What are your hobbies, interests, and typical recreational activities?

reading, movies, painting, cooking, making things, theatre

What do you like most about the community or cultural groups to which you belong?

My values are shared by those people; I'm lucky to live around like.

What do you like most about your family? not parochial; we have a world view; are interesting; look beyond ourselves; we have fun together

What do you like most about yourself? learned to be easy-going

What else should we know about you? I have made significant strides in understanding myself, understanding others; finding contentment over the last decade.

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