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 information is absolutely confidential. It is for professional use only.

Many thanks, Joy
Joy Sciabica joy@lightoflightyoga.com

Full name

Email add

Home add

Phone nur

Occupatio

Emergenc

Date 3/5/24

Yoga ~~~~~~

What motivated you to begin yoga therapy at this time?

~~Dia~~ Diagnosed w/ Parkinson Disease ~~3~~ 2012, Deep Brain Stimulation in 2018/2021 Battery replacement

Are there any particular benefits 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.

STRESS reduction, Balance, tremore control, TRYING to stay OFF Medication

Have you practiced yoga before? Yes ☑ No ☐
Do you currently practice yoga? Yes ☐ No ☑

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

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.

~~Bi~~ swimming, Bycycling (5 times a week, swimming once a week

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.

getting out of

Daily Routine

Do you have a typical waking routine? Yes ☑ No ☐

Do you have a typical preparation for sleep routine? Yes ☑ No ☐

Do you have a typical mealtime schedule? Yes ☑ No ☐

Sleep

How many hours do you usually sleep each night? 10 9-12; 12-7:00

On average, what time do you go to sleep and wake up? Sleep time 10 Wake time

Do you have difficulty falling asleep? Yes ☐ No ☑

Is your sleep typically uninterrupted? Yes ☒ No ☑

If not, what usually interrupts your sleep?

Going to the Bathroom (2-3 times per night)

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 describe your goals in this area.

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? Early PM When are you least energized? late PM

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 ☐

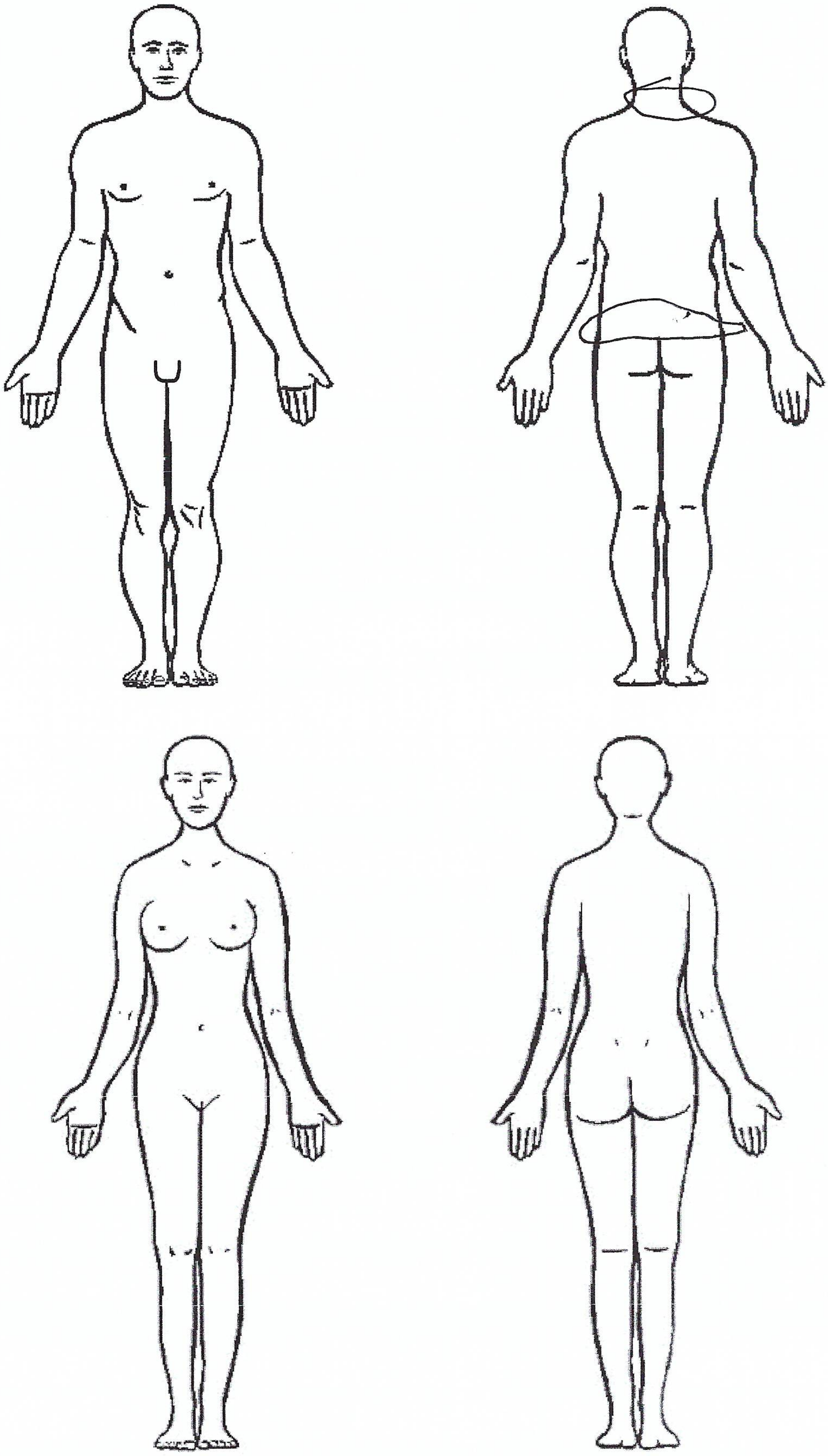
If yes, you are welcome to describe your primary stressors.

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

Exercise

Physical and Mental Health ~~~~~~

Health conditions. Please circle areas of pain, numbness, or discomfort.



Do you have a history of any of the following? Please check all that apply.

☒ Allergies (DUST)	☐ 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
☐ Chronic Pain	☐ Heart disease	☐ Seizures
☐ 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 ← PARKINSON'S	

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.
Dr. Kimberly Ruka - Neuro - Columbia Hospital - M.D. movement disorder

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.

Have you had any surgeries, major injuries, or hospitalizations? Yes ☑ No ☐
If yes, please note when and briefly describe each.
Deep Brain stimulation for Parkinsons; Broken collar Bone (Bike Accident (Aug 2021)

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 ☐

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.
several times a week; coffee (2 cups/day)

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.

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

Amitriptolene (sleeping pill.

If you would like to share any significant events that have shaped your life, please do.

getting PD

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 ☐ speech therapy (weekly)

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 affiliation to experiencing the wonders of the natural world. Yes ☑ No ☑

If yes, please briefly describe.

What aspects of your life are meaningful to you? Family

What inspires you? People who try to make the world a Better Place to live

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.

Bycycling

Mindfulness and Meditation

Do you practice mindfulness or meditation? Yes ☐ No ☑

If yes, please briefly describe.

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. ~~~