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..

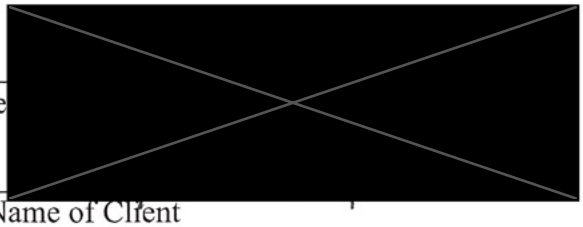
2. I recognize that I am choosing to participate in the Practicum in my current state of physical, mental, and emotional health. I understand that the Practicum may require physical exertion, and I represent and warrant that I am able to clearly communicate my physical capabilities and limitations, and 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.

Signature 

Printed Name of Client

March 23, 2024

Date

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 [redacted] Age 83 Personal Pronouns Date 03/23/2024
Email address [redacted]
Home address [redacted]
Phone number: cell [redacted] other
Occupation (previous if retired) Academic Advisor
Emergency contact: Name [redacted] Phone number: [redacted]

Yoga ~~~~~~

What motivated you to begin yoga therapy at this time?

Torn rotator cuff and balance problems. Spinal stenosis.

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.

Strength, flexibility, balance. Work arounds for shoulder.

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.

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.

Yoga class three times a week. Walking 1 mile in good weather.

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.

Reaching, twisting, standing for long periods of time.

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?

On average, what time do you go to sleep and wake up? Sleep time 10 Wake time 6

Do you have difficulty falling asleep? Yes ☐ No ☑

Is your sleep typically uninterrupted? Yes ☐ No ☑

If not, what usually interrupts your sleep?

urinating

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? Morning 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.

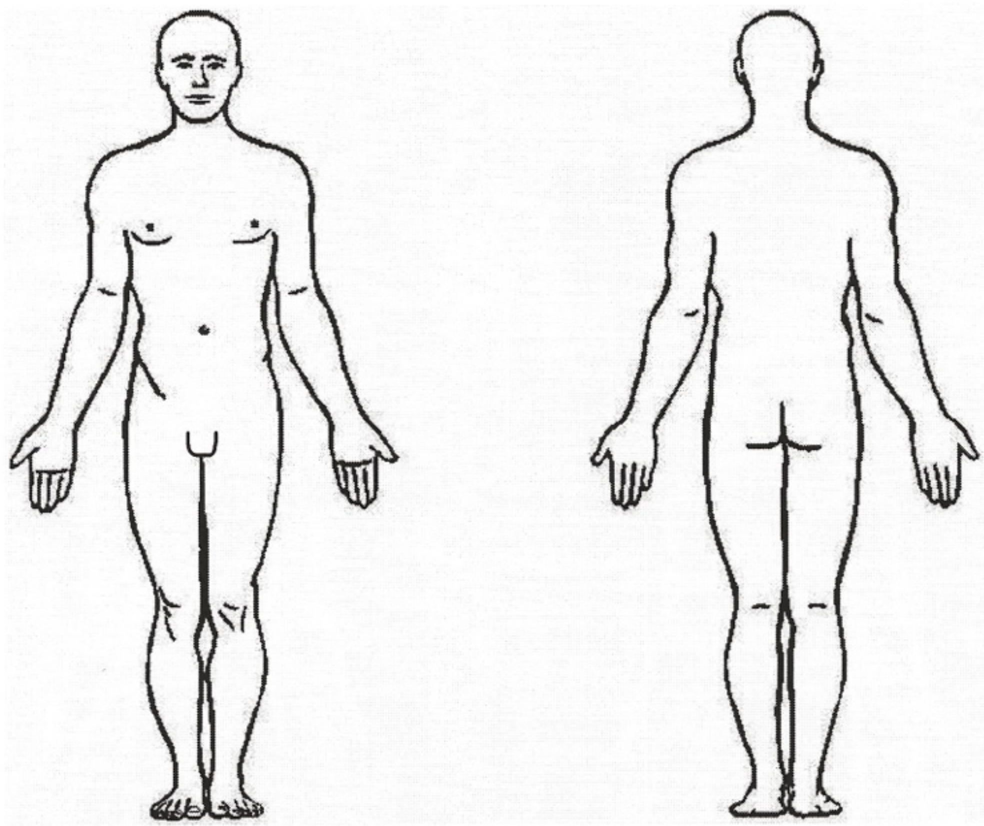
The news.

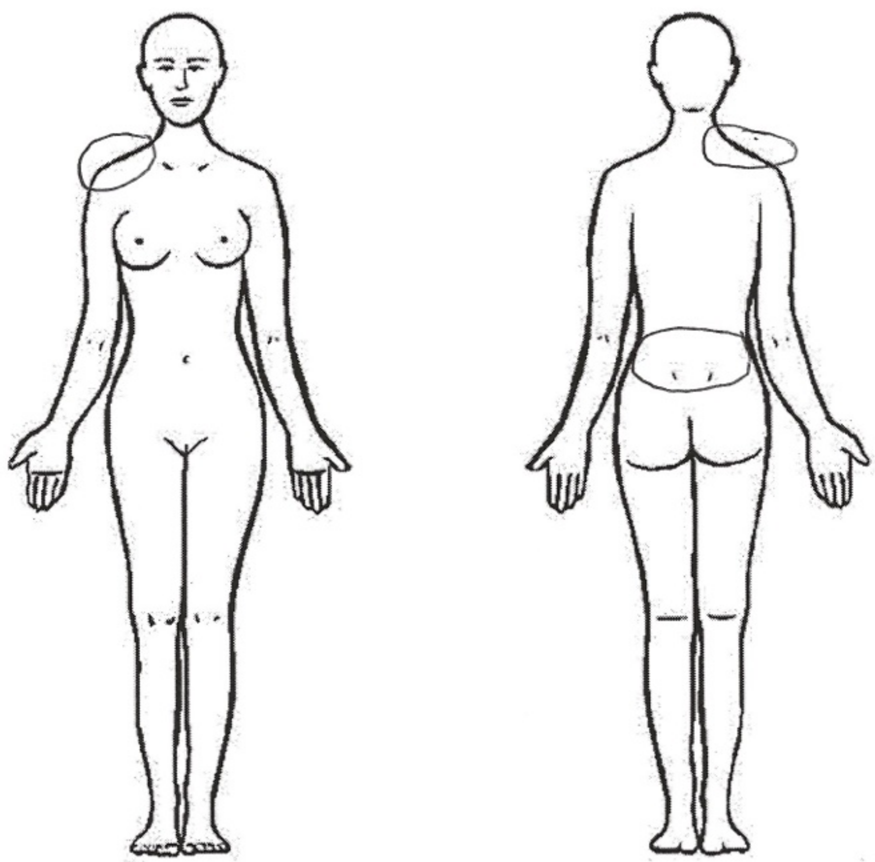
What do you do to cope with the stress in your life?

Yoga and meditation.

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 Spring	☑ 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	

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.

Blood pressure meds, osteoporosis meds

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.

Massage therapy every two weeks. Relaxing.

Have you had any surgeries, major injuries, or hospitalizations? Yes ☑ No ☐
If yes, please note when and briefly describe each.

Foot surgeries, hysterectomy, back surgery

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.

Alcohol – martini each evening

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.

Areds 2, Vit. B12, Miralax, Pravastatin, CoQ-10, Actonel, Lisinopril, Flonase (as needed)

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

Emergency surgery for ruptured disc thirteen yrs. ago.

Wisdom and Intellect ~~~~~~

What are you learning, curious about, and/or teaching others?

Mindfulness and forgiveness

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 ☐

Do you have a pet? Yes ☑ No ☐

Is loneliness a concern for you? Yes ☐ No ☐ Sometimes

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.

Meditation

What aspects of your life are meaningful to you? My family, my cat, my friends

What inspires you? Nature, orchids, reading

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.

Writing and reading poetry, listening to classical music, being with friends.

Mindfulness and Meditation

Do you practice mindfulness or meditation? Yes ☑ No ☐

If yes, please briefly describe.

Already did.

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.

None

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