Yoga Therapy Intake Form

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 on our work together, you can add additional information you would like to share at the last page.
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.
Please fill out this from and bring it to your first session. You can contact me if you have any questions.

Name _____**Karen**[redacted]_____ Date __**5/20/24**_____

Address (option) _[redacted]_____

Phone number _[redacted]_____ Can I leave a voice message? **Yes** / No
Email _[redacted]_____
What is the way to communicate? ☐ Email ☒ Phone ☐ Other

Profession _**R.N**._____
Weight _**222 lbs**_____ Height _**6ft**_____
Date of Birth __**11/22/57**_____

Emergency Contact Name: _[redacted]_____
Phone number: _[redacted]_____
Relationship: __**Husband**_____

What are your reasons for seeing a yoga therapist? **Relieve back pain and stress**

Are you familiar with Yoga? ☐Yes ☒ No

If yes, what is your experience? **N/A**

How long?

Type of yoga?

Do you currently exercise?

☐ *Regularly* ☐ *Occasionally* ☒ *Infrequently*

Please feel free to describe what kind and how often.

How would you your general health?

☐ *Great!* ☐ *Good* ☒*Okay* ☐ *Fair* ☐ *Poor*

Do you have injuries or limitations? **N/A**

Please briefly explain any specific condition you seek to improve through Yoga Therapy. **Lower back pain**

Are you currently under the care of a doctor or other healthcare provider?

☒ Yes ☐ No

If yes, please identify the reasons and provider(s):
I had my hip replaced in 2022.

How long have you had this condition?

How would you rate your stress level?

☐Low ☒ Moderate ☐ High ☐ Very high

Please feel free to describe the current sources of stress in your life. **Handicapped son and 93-year-old mother in assisted living.**

Please describe how you are handling stress**. I don't sleep well.**

Are you able to easily get up and down from the floor? ☐Yes ☒No **(I don't really get down on the floor too much, but I believe I am able to slowly). I lost 60 lbs since September.**

Do you feel your diet needs improvement? ☐Yes ☒ No

Do you currently use tobacco products? ☐Yes ☒ No

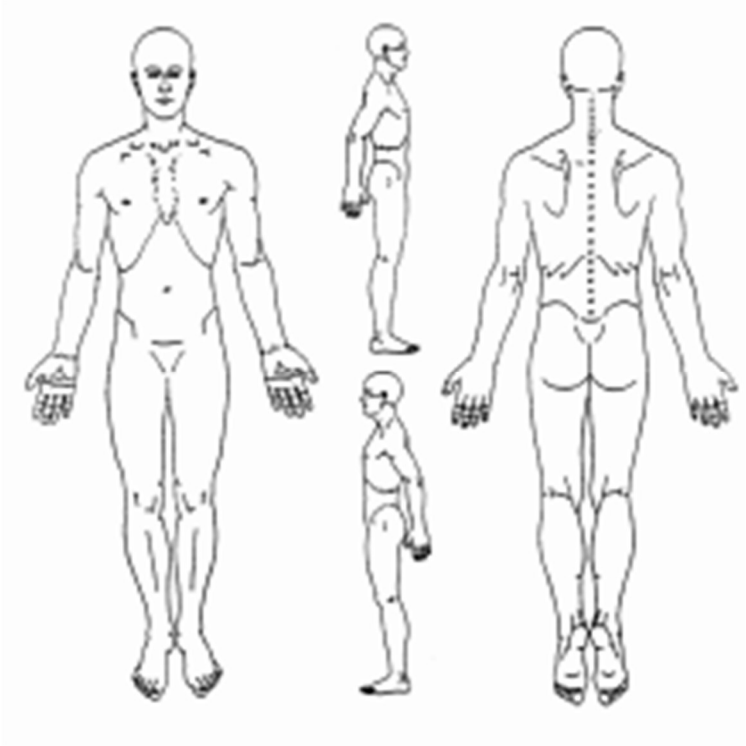
Have you ever used tobacco products? ☐Yes ☒ No

Do you inhale smoke in any form (tobacco, incense, marijuana)? ☐Yes ☒ No

How would you describe your social support system?

☐ Exceptional ☐ Strong ☒ Okay ☐ Marginal ☐ Poor

Do you have physical pain? ☒Yes **(occasionally)** ☐ No
If yes, please mark the places you experience pain in the image.



Lower back (left and right)

Please let any relevant physical and mental history (major injuries, surgeries, hospitalizations)

YEAR	CONDITION DIAGNOSED	TREATMENT	Current Status
2022		**Left Hip Replacement**	**Healed**

Please explain any mental health history if you have any. **N/A**

Please check any of the following conditions or issues that you have experienced:

☒ back pain (low, mid upper)	☒ high blood pressure	☒ insomnia
☐ disk /spinal problem	☐ stroke	☐ nausea & indigestion
☐ muscular injuries	☐ Low blood pressure	☒ elimination problem
☐ leg /foot pain crams	☐ dizziness / fainting	☐ diabetes
☐ circulatory problems	☒ fatigue	☐ physical abuse
☐ heart problem	☐ headache	☐ sexual
☐ edema (swollen hands/feet/veins)	☐ asthma	pregnant ☐Yes ☒ No due date:
☐ Arthritis	☐ respiratory problem	
☐ Cancer	☒ anxiety	
	☐ depression	

Please list any prescription or non-prescription drug you are taking, and what for?

Lisinopril – blood pressure

Levothyroxine – thyroid

Ambien – sleep

Motrin / Tylenol – pain relief

Eliquis – blood thinner

Energy and Breath

What time of day do you have the most energy?

☒Morning ☐ Mid-day ☐Evening ☐Night

Please share anything you'd like to tell me about your energy level **N/A**

When do you usually sleep (time asleep and time awake)? **10:30pm – 6:30am**

How would you describe the quality of your sleep?

☐Great ☐ Good ☐ Okay ☐ Fair ☒ Poor

If you experience fatigue, please describe its impact, frequency, and what you do to manage it. **I experience fatigue I think because I don't sleep well. I don't really manage it.**

Do you have any breathing challenges? ☐Yes ☒ No

How would you describe your breathing? **Normal**

Wisdom and Intellect

What are the major sources of intellectual stimulation and engagement in your life now? **I'm not sure.**

What are you in the process of learning and/or teaching others? **Nothing now.**

What would you like to learn and/or teach? **I want to learn how to manage my stress better.**

Connection and Meaning/Purpose

Do you have a religious/spiritual orientation? **I am a Christian and go to church weekly.**

What connection is important for your life and health (nature, family, pets, volunteering, etc.)?

Family, pets, and volunteering (in which I need to do more).

Do you feel connected in meaningful ways? **N/A.**

Do you feel that you know why you are here? (Alive on Earth) **To be cheerful and kind.**

What, if anything, should I know about your belief system or worldview? **N/A**

Is there anything else you would like to share? How can we best support you? **N/A**