YOGA THERAPY INTAKE FORM

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, and 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 in 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.

Name MR [redacted] Date AUG. 31, 2024

Address [redacted]

Phone number [redacted] Email [redacted]

Profession REAL STATE AGENT

Pronoun(s) MR. Weight 160 lbs Height 5'11"

Date of Birth OCT. 4, 1957 Age 66

Emergency Contact [redacted]

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 send to me the completed New Client Questionnaire before 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 me.

Anna Vasudevan 513-3745844 or annavasudevanyoga@gmail.com

Please answer the following questions or mark the answer most related to your response.

Why are you seeking Yoga Therapy?
FOR RELIEF OF PHYSICAL, MENTAL AND EMOTIONAL STRESS

Are you familiar with **Yoga**? (Yes) No

If so, what is your experience? PARTICIPATING IN CLASSES OFTEN ON

Medical provider

Are you currently under the care of a doctor or other healthcare provider? (Yes) No

If so, please identify the provider(s): MERCY AND UC HEALTH

Please briefly explain any specific condition you seek to improve through Integral Yoga Therapy.
WRIST PAIN, ANXIETY

Do you have a diagnosis from a health care practitioner about this condition? (Yes) No

How long have you had this condition? A FEW YEARS

Physical Body

Do you currently exercise? (Regularly) Occasionally Infrequently

If yes, what kind of exercise and how often?
RUNNING, WEIGHTS, 3 TO 5 TIMES A WEEK

How would you describe your general health? Great! (Good) Okay Fair Poor

Do you have injuries or limitations? WRIST, RIBS, PARKINSON'S

Diet

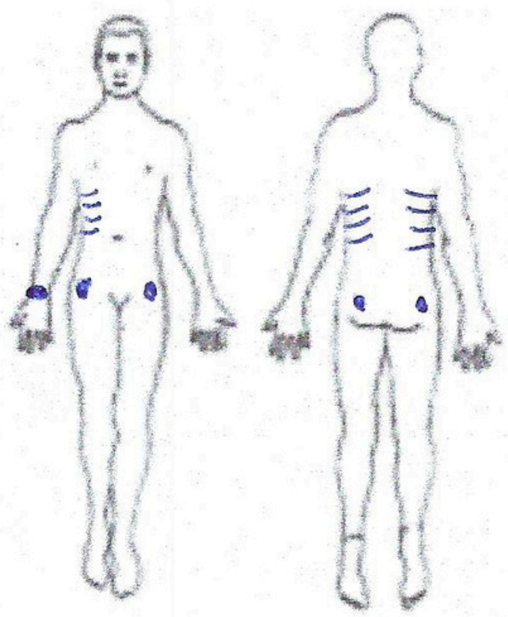
Do you feel your diet needs improvement? (Yes) No

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

Do you drink coffee or any other stimulant? How often? NO

Pain

Do you have physical pain? If yes, please mark the places you experience pain in the image to the right and feel free to elaborate on them. How much is your pain on a scale from 1 to 10?



Please list any relevant medical history (major injuries, hospitalizations, or surgeries)

(year event treatment outcome)

BROKEN 7 RIBS 2 YEARS AGO ON R SIDE
ONGOING WRIST INJURY - FAILED CARPAL TUNEL SURGERY

Please list any prescription or non-prescription drugs you are taking and describe what they are for.

BYTARY FOR PD - HYDROXYZINE FOR ANXIETY - MULTIVITAMINS
GLUCOSAMINE - JOINT HEALTH - STOOL SOFTNER - MELATONIN

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

ENERGY IS NOT A PROBLEM. TOO MUCH ENERGY IS A PROBLEM

When do you usually sleep (time asleep and time awake)? BETWEEN 2AM AND 9 AM

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. DAILY FRUSTATING, TRY TO GET MORE SLEEP - BETER SLEEP HIGIENE ***

How would you describe your breathing? INCONSISTENT

Mental Health

Please feel free to describe the current sources of stress in your life.

PARKINSON'S, 66 YEARS OLD HAVE YOU LISTENED TO THE NEWS LATELY?

How would you rate your stress level (circle one)? Low Moderate High Very high

*** I STRETCH, TAKE SUPPLEMENT, TRY TO SLOW BREATH, THINK POSITIVE, THC & ALCOHOL.

Please describe your practices, means, and coping mechanisms for handling stress (including allopathic and integrative approaches).

EXERCISE, SLOW BREATHING, POSITIVE FOCUS, THC

Please list any current mental health diagnoses and treatment.

ANXIETY

Please list any previous mental health diagnoses and treatment.

PSYCHOTERAPY
DEPRESSION

Please explain any relevant mental health history you think I should know.

MOM WAS EMOTIONALLY CHALLENGED

Wisdom and Intellect

What are the major sources of intellectual stimulation and engagement in your life now?
MY WORK, TALKING TO ROVENA

What would you like to learn and/or teach? MORE EFFECTIVE COMMUNICATION, HEALING AND STAYING POSITIVE UNDER STRESS

Connection and Meaning/Purpose

How would you describe your social support system? Exceptional ~~Strong~~ Okay Marginal Poor

Do you have a religious/spiritual orientation?

SLIGHTLY

What connection is important for your life and health (nature, family, pets, volunteering, etc.)? Do you feel connected in meaningful ways? NOT ENOUGH

GARDENING, PHYSICAL FITNESS, ROVENA, SCHMEDLEY

Do you feel that you know why you are here? (Alive on Earth)

NOT REALLY

What, if anything, should I know about your belief system or worldview? Is there anything else you would like to share? How can we best support you?

ALL WE HAVE IN LIFE IS LOVE AND THE PRESENT MOMENT.