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 74 Personal Pronouns Date 6-17-24
Email address [redacted]
Home address [redacted]
Phone number: cell [redacted] other
Occupation (previous if retired) Special ed teacher
Emergency contact: Name [redacted] Phone number: [redacted]

Yoga ~~~~~~

What motivated you to begin yoga therapy at this time?

To improve balance, increase flexibility and well being.

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, grief reduction, improve ~~posture~~ posture.

Have you practiced yoga before? Yes [X] No [ ]
Do you currently practice yoga? Yes [X] No [ ]

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

None at this time.

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 [X] No [ ]
If yes, please describe. Such as activities, frequency, self-directed or guided, duration, intensity.

Walking 2 miles daily (depends on weather), Yoga class 1 day 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.

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? UP

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

Do you have difficulty falling asleep? Yes ☐ No ☐

Is your sleep typically interrupted? Yes ☐ No ☐

If your sleep is interrupted, what usually wakes you up?

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? When are you least energized?

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

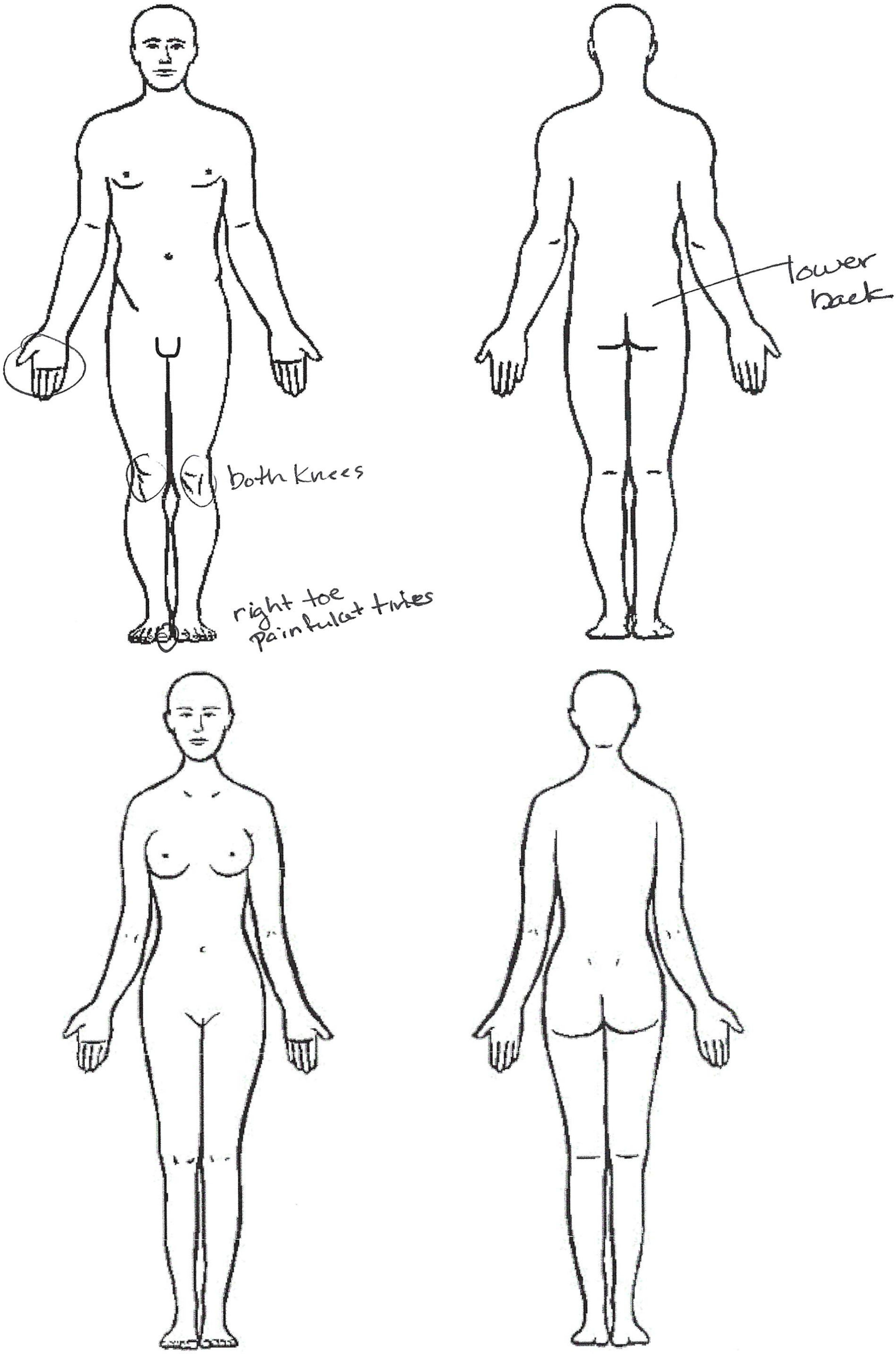
Are there any specific life circumstances contributing to your stress level now? Yes ☐ No ☐

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

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

Physical and Mental Health ~~~~~~

Health conditions. You may describe areas of pain, numbness, or discomfort here:



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

[X] Allergies	[ ] Elimination~ constipation, diarrhea	[X] Neuropathy, tingling, numbness light at times
[ ] Anxiety or panic attacks	[ ] Eye disease	[ ] Osteoporosis, osteopenia
[X] Arthritis	[X] Fatigue, lethargy, low energy	[ ] PMS/Menstrual pain
[ ] Asthma	[ ] Head injury~ TBI, concussion(s)	[ ] Respiratory condition(s)
[X] Cancer, Type (Skin)	[X] Headache, migraines	[X] Sciatica
[ ] Chronic Pain	[X] Heart disease	[ ] Seizures
[ ] Circulatory issues, swelling	[X] High blood pressure	[ ] Stroke
[ ] Depression	[ ] Insomnia, sleep issues	[X] Thyroid condition(s)
[X] Diabetes	[X] Joint pain	[X] Urinary condition(s)
[X] Digestive/gastrointestinal illness	[ ] Memory issues	[ ] Weight concerns
[ ] Difficulty concentrating/focusing	[X] 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 [X] No [ ]
If yes, please list any diagnoses, type of provider, and current treatments.

Heart- Dr. Jones - Cardio Thyroid - Dr. That (GP)
Type II Diabetes - Dr. Tingley - Endo

Have you tried other integrative therapies such as acupuncture, chiropractic care, massage therapy, or ayurveda? Yes [X] No [ ]
If yes, please note the type of care and its effects.

Chiropractic as need, Massage every 2 weeks.

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

Tonsils - 1955
Gallbladder - 1988
Hernia-belly button - 2010
R knee replacement - 2018
Paraesophageal hernia - 2023 same day R/L Inguinal hernia

Do you have a history of trauma or current/ongoing traumatic circumstances in your life?
Yes [X] No [ ] Son heroin addict | bi-polar (deceased)

Do you have a history of substance abuse/addiction? Yes [ ] No [X]
Are you in recovery presently? Yes [ ] No [X]

Do you consume any of the following substances: alcohol, caffeinated beverages, tobacco products, or marijuana? Yes [X] No [ ]
If yes, please note the substance and typical daily or weekly consumption of each below.

Coffee - 1 cup daily
alcohol - 1-2 glasses a week

Are you receiving professional psychiatric care for any of the above or other mental health concerns? Yes [ ] No [X]
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.

Januvia-50 AMODIPINE - 5MG levothyroxine-88MCG Coreg-25 MG
Metformin - 2(500) 2xday Cozar(Losartan) - 50 MG atorvastin - 10MG B12, Vit D

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

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 ☐

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 (grandsons), Frriends, Neighb... I have a very active social life.

What inspires you? - Helping family / friends.

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.

Travel, Assisting friends with physical/memory issues.

Mindfulness and Meditation

Do you practice mindfulness or meditation? Yes ☒ No ☐

If yes, please briefly describe.

Working on meditation techniques.

If no, are you interested in exploring meditation? Yes ☒ No ☐ to improve

Anything else?

You are welcome to share any other related thoughts, questions, or concerns that you may have.

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