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, 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 on 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 _____S.S._____01/24/2025_____Date

_____ Address

_____ Phone

number _____ Email _____

Profession _____

Pronoun(s) _____Weight _____Height _____

Date of Birth _____ Age_____

Emergency Contact _____

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 bring the completed New Client Questionnaire to 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 your practitioner:

Please mark the answer most related to your response.

Are you familiar with Yoga? *Yes No* If so, what is your experience? Yes, I have done yoga ,

regularly ,since 15 year with interruption

Do you currently exercise? *Regularly Occasionally Infrequently* Please feel free to describe what kind and how often. Yes bike riding and yoga

How would you describe your general health? *Great! Good Okay Fair Poor* Do you have injuries or limitations? Okay No limitations

Please briefly explain any specific condition you seek to improve through Integral Yoga Therapy. Back ,shoulders , flexibility and strength

Are you currently under the care of a doctor or other healthcare provider? *Yes No* If so, please identify the provider(s): no

Do they know you are seeking support through Integral Yoga Therapy? no

Do you have a diagnosis from a health care practitioner about this condition? *Yes No* How long have you had this condition? Allergies

How would you rate your stress level (circle one)? *Low Moderate High Very high* Please feel free to describe the current sources of stress in your life.

High , stress form work,I have to do overtime since the begging of the year

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

Weekly yoga, family support, limiting other social interactions and delegate housework

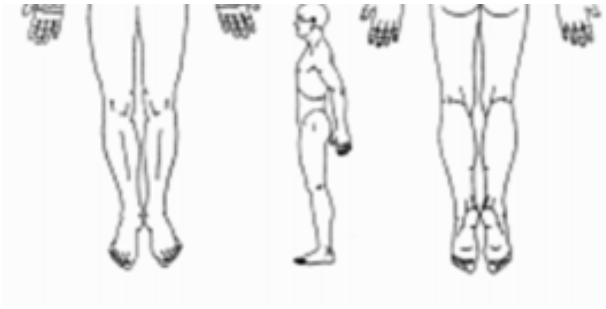
Are you able to easily get up and down from the floor? X *Yes* Do you feel your diet needs improvement? Yes Do you currently use tobacco products? No

Have you ever used tobacco products? *No* Do you inhale smoke in any form (tobacco, incense, marijuana)? *No*

How would you describe your social support system? Strong

Exceptional Strong Okay Marginal Poor

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.



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

YEAR	EVENT	TREATMENT	OUTCOME

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

back pain (low, middle or upper back)

disc problems

other spinal/skeletal problems muscular injuries

leg pain or cramps

circulatory problems

heart conditions

edema (swollen hands or feet) varicose veins

arthritis (where?)

_____

X fatigue

headaches

X allergies

X asthma

other respiratory problems

physical abuse

sexual abuse

psychological abuse

stress

anxiety

depression

insomnia

nausea & indigestion

elimination problems

cancer

diabetes

are you currently pregnant? due date

_____

Other Conditions:

high blood pressure

stroke history

low blood pressure, dizziness or fainting

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

Energy and Breath

What time of day do you have the most energy? M*orning Mid-day Evening Night* Please share anything you'd like to tell me about your energy level I have more energy in the evening

When do you usually sleep (time asleep and time awake)? Due to work, it fluctuates but it can get late and I like to sleep in if possible , I like to sleep on the weekends

How would you describe the quality of your sleep? *Good*

please describe its impact, frequency, and what you do to manage it. I some don't get enough time to

sleep, but if I do get enough sleep I do feel rested

Do you have any breathing challenges not mentioned above? No

How would you describe your breathing? Chest breathing

Mental Health

Please list any current mental health diagnoses and treatment.

CONDITION DIAGNOSED	YEAR DIAGNOSED	CURRENT TREATMENT (Prescription, OTC, Behavioral, etc.)	CURRENT STATUS
Panic attack while driving	October 2023	Deep breathing	Occasionally

Please list any previous mental health diagnoses and treatment.

CONDITION DIAGNOSED	YEAR DIAGNOSED	MEDICATIONS	HOSPITALIZATONS	THERAPY

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

If you did not include prescription or non-prescription drugs you are taking for mental health, please list and describe what they are for. None

Wisdom and Intellect

What are the major sources of intellectual stimulation and engagement in your life now?

Work, reading and talking to family and friends

What are you in the process of learning and/or teaching others? I am teaching nursing

students, I have to learn about a multitude of things, including nutrition, palliative care.I

think this is interesting and challenging Adjusting to constant change.

What would you like to learn and/or teach?

I want to learn more about movement and exercise , diet

Connection and Meaning/Purpose

Do you have a religious/spiritual orientation? I am catholic and I used to go to church more regularly but I stoped because I no longer feel connected to the catholic church.I like the interaction with the community. To support each other.

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

Family and friends , yoga and eating with family and cooking together ,Music

Do you feel connected in meaningful ways? Yes

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

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?