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

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 *79* Personal Pronouns *Mrs.* Date *5/3/2024*
Email address [redacted]
Home address [redacted]
Phone number: cell other [redacted]
[redacted]etired) *BooKeeper/Accounting,*
Emergency contact: Name [redacted] Phone number: [redacted]

Yoga ~~~~~~

What motivated you to begin yoga therapy at this time?

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.

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.

No

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.

Silver SneaKers 2x week Yoga 3 x week
Gardening

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.

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 nighttime 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:p.m. **Wake time** 6:30 AM.

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?

A

Do you typically wake up feeling refreshed? Yes ☐ No ☐

Eating Patterns

eating, aligning eating patterns with overall wellness goals.

Yes ☐ No ☐

If yes, you are welcome to describe your goals in this area.

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? AM **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 ☐

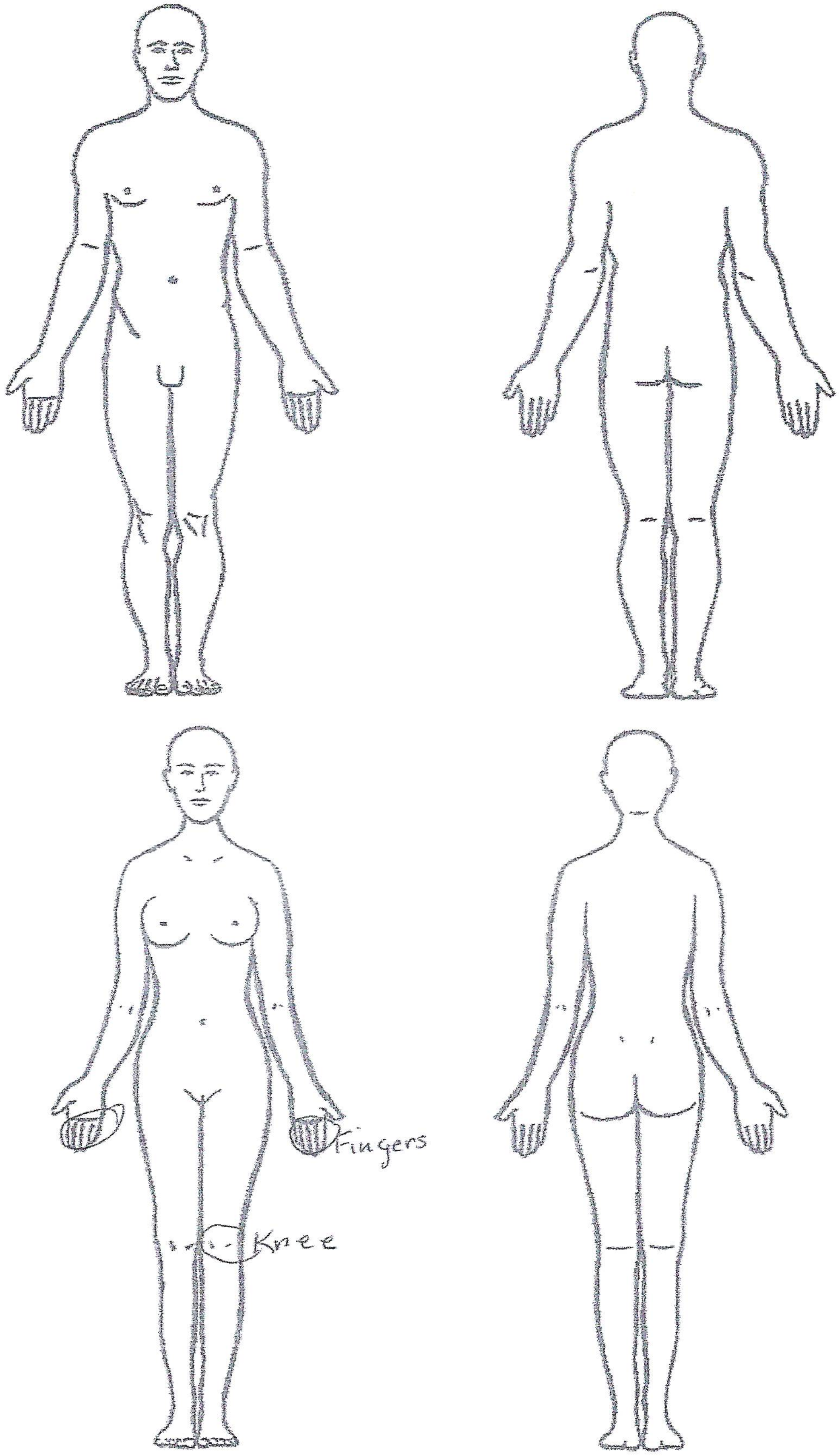
If yes, you are welcome to describe your primary stressors.

Death of Husband, 2 Sisters, 1 Nephew within 2 years

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.

☑ Allergies	☐ 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 Breast	☐ Headache, migraines	☐ Sciatica
☐ Chronic Pain	☐ Heart disease	☐ Seizures
☐ Circulatory issues, swelling	☐ High blood pressure	☐ Stroke
☐ Depression	☐ Insomnia, sleep issues	☑ Thyroid condition(s) Hypo
☐ 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.

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.

Have you had any surgeries, major injuries, or hospitalizations? Yes ☑ No ☐
If yes, please note when and briefly describe each.
Lump From Breast. 30 yrs ago

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.
Coffee in morning

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.

Rosuvastatin 5mg, Metoprolol 25mg, Babyaspirin, Lisinopril 5mg As needed, Levothyroxin 100mg
PreserVision, OsteoBi-Flex, D3 25mg (1000IU) Zyrtec

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.

Church Also Enjoy Nature

What aspects of your life are meaningful to you?

Church - Friends - Family - Gardening

What inspires you? Positive People

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.

Gardening - Beautiful Flowers + Plants Growing Seed, watching Them Grow.

Mindfulness and Meditation

Do you practice mindfulness or meditation? Yes ☐ No ☒

If yes, please briefly describe.

If no, are you interested in exploring meditation? Yes ☐ No ☐ ~~Maybe~~ Maybe

Anything else?

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

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