Blossoming Lotus
Intake and Assessment
703-606-1698
Tia@BlossomingLotus.yoga

BASIC PERSONAL INFORMATION			Clinician ONLY
Name: m		Date:	Preferred Name:
Age: 15	Gender Identity: F	Who referred you? ☒ Self ☐ Clinician: _____ ☐ Other: _____	Preferred Pronouns: she/her
What major concerns do you wish to address through Yoga: ☒ Physical: _____ ☐ Emotional: _____ ☐ Mental: _____ ☐ Spiritual: _____ ☐ Relationship: _____ ☐ Other: _____	What are your three main goals for yoga therapy: Flexibility core strength endurance	What is your intention in seeking yoga therapy: Improve way body moves	Notes:
YOGA PRACTICE BACKGROUND			Clinician ONLY
How long have you practiced? ☒ No experience – 0 years ☐ < 1 year ☐ 1-3 years ☐ 4-5 years ☐ 6-10 years ☐ >10 years	How often do you practice? ☒ Not applicable ☐ < 1x per week ☐ 1-2x per week ☐ 3-4x per week ☐ >5x per week ☐ Other: _____	How long is each session on average? ☒ Not applicable ☐ 15-30 minutes ☐ 31 to 45 minutes ☐ 46 to 60 minutes ☐ 61 to 90 minutes ☐ Other: _____	Notes:
What is your favorite kind of yoga? ☐ Hatha ☐ Yin/restorative/meditative ☐ Vinyasa other flow ☐ Iyengar ☒ Other: ?	Where do you practice most? ☐ Yoga studio ☐ Fitness Rec Center ☐ Home on my own ☐ nline ☒ Other: never	Do you have other mind-body practices? e.g.,: ☐ artial Arts ☐ ai i _____ ☒ NO ☐ _____	Likes/dislikes related to practice

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Circle how often you engage in the following yoga practices:

- Aspiring to lead an ethical life — often sometimes never
- iving in a nonviolent ay — often sometimes never
- Being truthful — often sometimes never
- Not taking what is not freely offered to me — often sometimes never
- Living in moderation — often sometimes never
- Not being greedy — often sometimes never
- Aspiring to lead a purposeful life — often sometimes never
- Living with purity (eating healthy food or keeping a clean living space) — often sometimes never
- Living with equanimity (remaining calm, not getting attached) — often sometimes never
- Living with discipline (having a regular routine, e sports or meditation) — often sometimes never
- Living with introspection (paying attention to my thoughts and feelings) — often sometimes never
- Living with purpose (dedicating myself to creating meaning) — often sometimes never
- Aspiring to a life that honors the health and wellness of my body — often sometimes never
- Posture (asana) practice — often sometimes never
- Aspiring to a life in which mind and body connect — often sometimes never
- Breathing practices — often sometimes never
- Aspiring to a life of mindful introspection — often sometimes never
- Becoming quiet and looking inward — often sometimes never
- Avoiding too much stimulation — often sometimes never
- Aspiring to a life of concentrated awareness — often sometimes never
- Practices such as guided imagery or relaxation training — often sometimes never
- Practices such as body scans or other body awareness exercises — often sometimes never
- Aspiring to a life of meditative awareness — often sometimes never
- Sitting in meditation — often sometimes never
- Walking in meditation — often sometimes never
- Aspiring to a life that connects body, mind and spirit — often sometimes never
- Experiencing a connection to a greater whole—feeling complete — often sometimes never
- Experiencing inner joy — often sometimes never

oals for practice

PHYSICAL HEALTH INFORMATION

Who is your primary care provider:
Name: N/A
Address:
Contact Information:

If you do not have a PCP, would you like us to make a referral:
- ☐ Yes, please
- ☒ No, thank you
- ☐ Ask me later

CLINICIAN ONLY

Make PCP referral OR
Obtain release of information as needed

Client: MM

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Are you struggling with any of the following:

- ☐ Addiction / alcohol / drugs
- ☐ Adrenal fatigue / illness
- ☑ Allergies
- ☐ Anxiety
- ☒ Arthritis
- ☐ Autoimmune disease
- ☐ Cancer
- ☐ Chronic Pain
- ☐ Dementia
- ☐ Depression
- ☒ Diabetes
- ☒ Digestive/gastrointestinal illness
- ☐ Eating disorder / anorexia / bulimia
- ☐ Head injury
- ☐ Heart disease
- ☒ High blood pressure
- ☒ High cholesterol
- ☐ HIV/AIDS
- ☐ Kidney disease
- ☐ Liver disease / hepatitis
- ☐ Lung disease / Asthma / COPD
- ☑ Menopause
- ☒ Musculoskeletal concern
- ☐ Movement Disorder
- ☐ Neurological disease
- ☐ Osteoporosis
- ☐ Schizophrenia
- ☐ Sciatica
- ☐ Skin problems
- ☐ Sleep problems
- ☐ Stroke
- ☐ Thyroid issues
- ☐ Vision problems / eye disease
- ☐ Weight concerns
- ☐ Other: _____

not "struggling" but have.

Have you had surgeries?
If yes, please describe, date

Bilateral knee 1972/80
Hysterectomy 1992
(L) wrist 1998
(R) ankle 1998

Have you been hospitalized?
If yes, please describe the reason, date, how long:

no

When was your last (approximately):

- ☒ Physical exam: April 2025
- ☒ Vision exam: March 2025
- ☒ Dental check-up: March 2025
- ☒ Hearing test: May 2022
- ☐ Other:
- ☐ Other:

Have you had any injuries or accidents?
Please list, date:

- ☐ multiple ankle
- ☐ injuries any
- ☐ the years

What medications are you currently taking:
(please list all; if possible give reason and dosage)

- ☒ None of your concern
- ☐
- ☐ for all items
- ☐
- ☐ checked in list
- ☐
- ☐ box
- ☐
- ☐
- ☐
- ☐
- ☐

What supplements (e.g., vitamins, minerals, herbs) are you currently taking:
(reason, dosage)

- ☐ Vitamin D + K
- ☐ multivitamin
- ☐
- ☐
- ☐ no alcohol
- ☐
- ☐ no smoking
- ☐
- ☐
- ☐
- ☐
- ☐

Follo p on all endorsed items

Ask about alcohol and smoking

Do you have limitations in physical activity level? If yes, please describe.

no

Explore if movement aggravates or relieves

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Client: M

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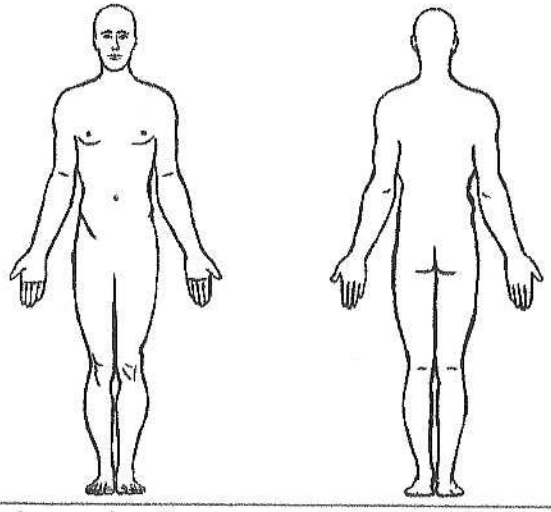
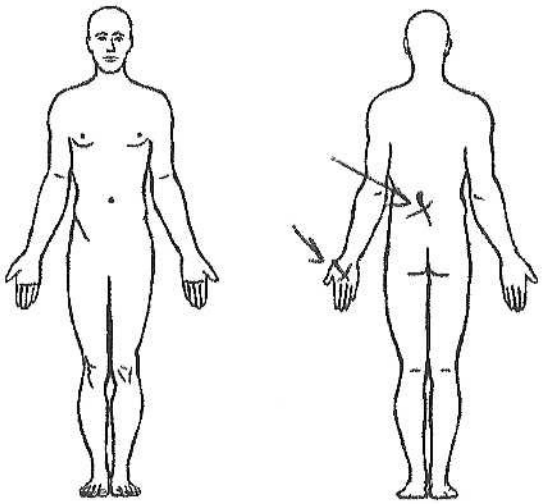
Please **mark where you currently experience ACUTE pain**



Please **mark where you experience CHRONIC pain**



As for pain rating from 1 to 1 for each indicated area

Explore if movement aggravates or relieves:

How is your sleep?

Wake-up time: 0500 AM

Do you use an alarm to wake: (yes) no

Bedtime: 9-930 PM

Do you fall asleep easily? (Yes) no

Hours of uninterrupted sleep per night? 7½-8

Do you feel tired upon waking? Yes (no)

How much do you move every day?

How many hours do you sit each day (at work plus at home): 12 hours

Can you move as well as you would like? yes (no)

What types of exercise do you do: none

Type: _____ times per week: _____

number of minutes each time: _____

Type: _____ times per week: _____

number of minutes each time: _____

Type: _____ times per week: _____

number of minutes each time: _____

How is your nutrition (food and drink)?

Typical breakfast: cereal milk

Typical lunch: sandwich

Typical dinner: sandwich or soup

Typical snacks (including when): Nuts @ night

How much do you drink of each of the following per day:

Water: 5-6 glasses ounces o

Regular soda: Ø o

Diet soda: Ø o

Coffee or black/green tea: green/black tea 2-3 cups

Herbal tea: Ø o

Juice: Ø o

Alcohol: Ø o

Other Ø : _____ o

Explore quality of sleep

- ☐ Initial insomnia
- ☐ Middle insomnia
- ☐ Terminal insomnia
- ☐ Night terrors, sleep walking
- ☐ Other sleep disturbance

Follow up on any movement issues

Explore exercise in more detail

Explore quality of nutrition – be sure ask about food AND drink

for vegans, vegetarians explore:

- ☐ protein sources
- ☐ b vitamin sources
- ☐ omega 3 sources

Note strengths

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PSYCHOLOGICAL and EMOTIONAL INFORMATION

How would you describe your **temperament** (e.g., introverted, extroverted, outgoing, sociable, loner, intense, easy going, etc.)? introverted loner

Do you have any mental health **concerns, symptoms, or diagnoses**? Please describe

No

Have you received **mental health therapy or counseling**? Where, when, how long, how often?

No

Have you ever attempted or thought about suicide? (Yes) No

during divorce

Have you ever attempted or thought about harming someone else? Yes (No)

Do you have a **history of mistreatment or abuse**? Yes (No)

Please explain to the degree comfortable:

CLINICIAN ONLY

Follo p on diagnoses symptoms incl ding onset, fre ency, d ration, severity

Assess duties (protect, warn, report)

Explore if mental health treatment has been received at PCH

Please check the best answer for each of the following items for the **PAST 7 DAYS:**	*Never*	*Rarely*	*Sometimes*	*Often*	*Always*
I felt fearful	↘				
I found it hard to focus on anything other than my anxiety	↘				
My worries overwhelmed me	↘				
I felt uneasy	↘				
I felt worthless	↘				
I felt helpless	↘				
I felt depressed	↘				
I felt hopeless	↘				

From PROMIS-29 v2.0

Conduct Mini MSE

Mood:
Affect:
Thought process:
Orientation * 3:
Other:

Are you experiencing stress in any of the following areas?
Please check all that apply: no

- ☐ Chronic pain / illness / health
- ☐ Caretaking a child or an elder
- ☐ Discrimination / Bias
- ☐ Divorce / Separation
- ☐ Economics / Money
- ☐ Family
- ☐ Grief / Death
- ☐ Identity
- ☐ Loss (e.g., job, home)
- ☐ Nutrition / Food
- ☐ Moving/Relocation
- ☐ Partner relationship
- ☐ School
- ☐ Sexuality / gender identity
- ☐ Sleep
- ☐ Substance use
- ☐ Traumatic event – nonpersonal
- ☐ Traumatic event – personal
- ☐ Work
- ☐ Other: _____

How well are you able to **cope with stress**? v. well

What do you typically do when stressed? deal with cause

What do you do that helps you cope? evaluate + act

What do you do that gets in the way? procrastination

Follow up on all checked items

Note strengths

SOCIAL, SOCIETAL, and SOCIOECONOMIC INFORMATION

What is your highest educational level?

- ☐ Less than high school
- ☐ High school / GED
- ☐ Some college no degree
- ☐ Associate degree
- ☐ Baccalaureate degree
- ☒ Masters degree
- ☐ Doctoral degree
- ☐ Other:

What was your degree major: _____

What is your current employment?

- ☐ Unemployed
- ☒ Employed – answer questions below:

Job title: Supervisor

Where: government

How long: 40yr

Hours worked per day: 8+

(Sedentary) or mobile:

How is your work-life balance? poor

Do you work too much?
(Not at all) somewhat quite a bit a lot

How much do you enjoy your work?
Not at all somewhat (quite a bit) a lot

How stressful is your work?
Not at all (somewhat) quite a bit a lot

Does work leave enough family time?
Not at all (somewhat) quite a bit a lot

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plore impact on physical and mental health

Describe your social support network: Do you have:

- ☒ Close friends; how many: 1
- ☒ Casual friends /social friendships
- ☒ Work / peer relationships
- ☒ Positive immediate family relationships
- ☐ Meaningful extended family relationships
- ☐ Community supports (e.g., via church, clubs)

Describe your home environment:

Do you rent or own? own

How many people live with you in your home: 0

What is the quality of your home? nice

Describe your **neighborhood:** HOA in small town

Have you ever experienced any of the following **socioeconomic challenges?**	*Yes, at current*	*Yes, in the past*	*No, never*
No income			X
Poverty level income			X
Homelessness			X
Food insecurity			X
Economic / financial deprivation			X
Unsafe neighborhood			X
Oppression because of your socioeconomic status			X
Other:			
Have you ever experienced any of the following sociopolitical or legal circumstances?	*Yes, at current*	*Yes, in the past*	*No, never*
Immigration concerns			X
Exposure to a polluted environment /toxins			X
Engaged in political activism			X
Engaged in criminal activity			X
Been a victim of criminal activity			X
Other:			

Follow up on any endorsed items (if none, inquire)

Note strengths

Client: VM

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CULTURAL and FAMILIAL INFORMATION						CLINICIAN ONLY
Please check the best answer for each of the following **cultural and family experiences** based on the present moment:	*Never*	*Rarely*	*Sometimes*	*Often*	*Always*	
I feel a strong sense of cultural or community belonging based on common beliefs and values			X			Follow up on all endorsed items; if none, inquire
I embrace important spiritual/religious beliefs, ethics, and morals			X			
I feel strong emotional ties to a cultural or community group		X				
I have experienced prejudice, bias, or oppression because of my cultural or community group memberships	X					Explore family dynamics (relationships across generations, behavioral patterns, shared values, attachment styles)
I have experienced rejection, stigma, or ostracism	X					
I experience intergenerationally transmitted / historical trauma	X					
I experience strong emotional ties to a significant other		X				Explore family structure (stability, cohesiveness, divisiveness, closeness, distance, and boundaries)
I experience strong emotional ties to my immediate family			X			
I experience strong emotional ties to my extended family		X				
I experience conflict in some of my family relationships		X				
My family holds strong shared values and beliefs			X			

What are your most important life values? fairness	What are your spiritual or religious beliefs? none	What is your most important community or cultural group? friends	Explore family communication styles
Where did you learn or develop these? home	Where did you learn or develop these?	How engaged in or isolated from this group are you? engaged	

What are your hobbies, interests, and typical recreational activities?
reading, gardening, needlework, dogs

What do you like most about the community or cultural groups to which you belong?
interesting

What do you like most about your family?
relatively middle of the road

What do you like most about yourself?
experienced, low-key

What else should we know about you?
?

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CLINICIAN ONLY – Behavioral Observations		CLINICIAN ONLY
Alignment (make notes as needed) ❑ Ears over shoulder ❑ Shoulders forward or backward ❑ Shoulders align over hips ❑ Upper back hunched (kyphosis) ❑ Shoulders collapsed ❑ Knee over ankles ❑ Ear over ankles ❑ Accentuated lower lumbar (lordosis) ❑ Feet straight ❑ Knees caps forward ❑ Hips rotation ❑ Pelvis anterior or posterior rotation ❑ Shoulders / clavicles even ❑ Hyperextension in joints	**Challenges Noted In** (make notes as needed): ❑ Balance ❑ Endurance ❑ Flexibility ❑ Gait ❑ Posture ❑ Strength **Strengths Noted In** (make notes as needed): ❑ Balance ❑ Endurance ❑ Flexibility ❑ Gait ❑ Posture ❑ Strength	Notes:

CLINICIAN ONLY – Information to Review with the Client	CLINICIAN ONLY

- ❑ The clinic provides all necessary props, but you are welcome to bring your own mat.
- ❑ Discuss dates and times of the class (Mondays at 6pm, starting 1/30/2017)
- ❑ Emphasize that clients need to make an effort to be at all 10 sessions; it is a 10 week commitment. Ask clients to come 15-20 min early for the first session to fill out paperwork, and 5 min early before each class after that.
  - ❑ What would make it harder for you to attend the class? (i.e., Barriers):_____
    _____
  - ❑ What would make it easier for you to attend the class? (i.e., Facilitators):_____
    _____
- ❑ Discuss format of the class: introductory talk/discussion about yoga psychology, breathing practice, physical practice. Inform clients that while they are not required to participate in the discussion, it is going to be a regular component of the sessions.
- ❑ Voluntary adjustments are offered by the teachers; all hands-on work is very light and respectful. If you prefer not to be touched, please let us know. We can make verbal adjustments that do not require hands on your body. Adjustments are given in a spirit of support and offering a more healthful way- there is no wrong way to do yoga!
- ❑ Physical Adjustments? (Y/N): _____
- ❑ We will offer many modifications using props (e.g., blocks, straps); please be true to yourself and to your body- if something feels wrong, do NOT do it.
- ❑ Feel free to ask questions about anything we do- before class, after class, and during class
- ❑ Yoga is best practiced in comfortable clothes that will allow for stretching, as well as coverage throughout the class (e.g., clothes that do not slip).
- ❑ Yoga is best practiced on a relatively empty stomach, but not starving (a light snack prior to class will help you maintain your energy without being too full). Please refrain from eating heavy meals 2-3 hours before practice.
- ❑ Also, we ask that if you have any medical conditions that may affect your yoga practice, you let us know, so that we can help you with modifying poses for particular reasons.
- ❑ Please come a few minutes early to give yourself time to settle in on your mat.

- ❑ There will be space in the corner of the room to store your personal belongings.
- ❑ Please turn off all cell phones before you settle in for class.

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