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 Sciabica joy@lightoflightyoga.com

Full name [redacted] Age 63 Personal Pronouns she/her
Date 04/29/2024
Email address [redacted]
Home address
Phone number: cell other
Occupation (previous if retired)
Emergency contact: Name Phone number:

Yoga ~~~~~~

What motivated you to begin yoga therapy at this time?

Invitation from yoga therapist.

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.

All of the above

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.

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

yoga 4 times a week and swim 2 days

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.

Lowering and getting up from the floor, limited range of motion on left leg

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? 9

On average, what time do you go to sleep and wake up? Sleep time 1000 Wake time 800

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?

going to the bathroom

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? 3 When are you least energized? 2

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.

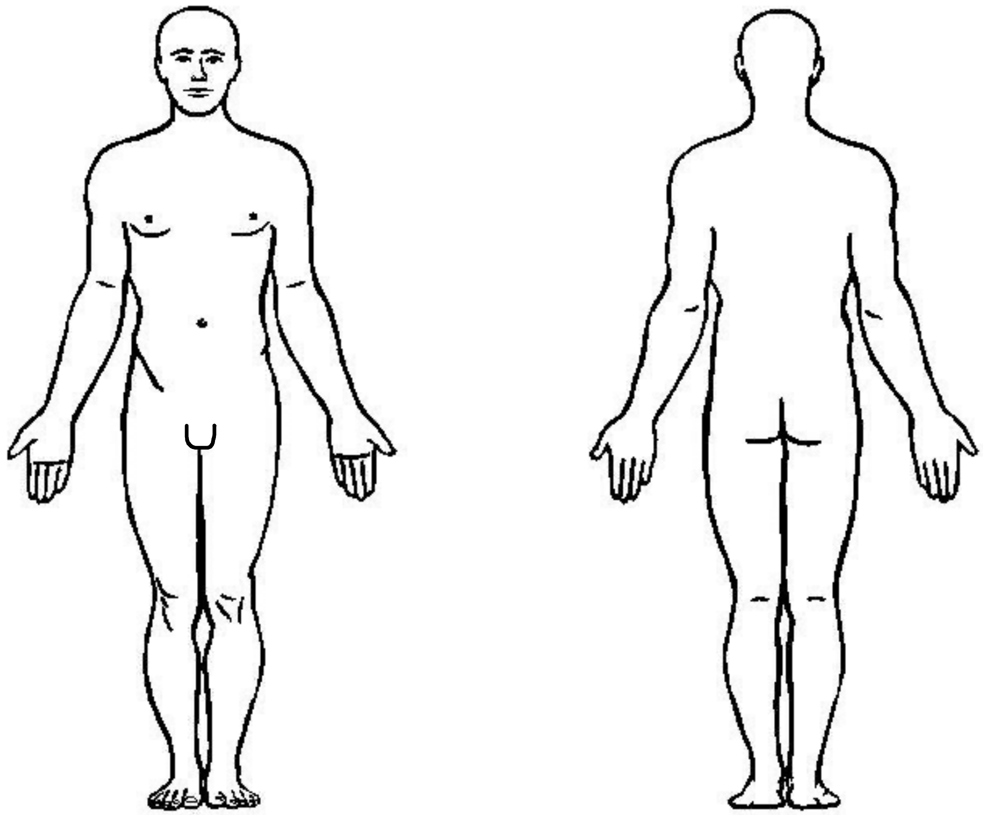
physical limitations, money

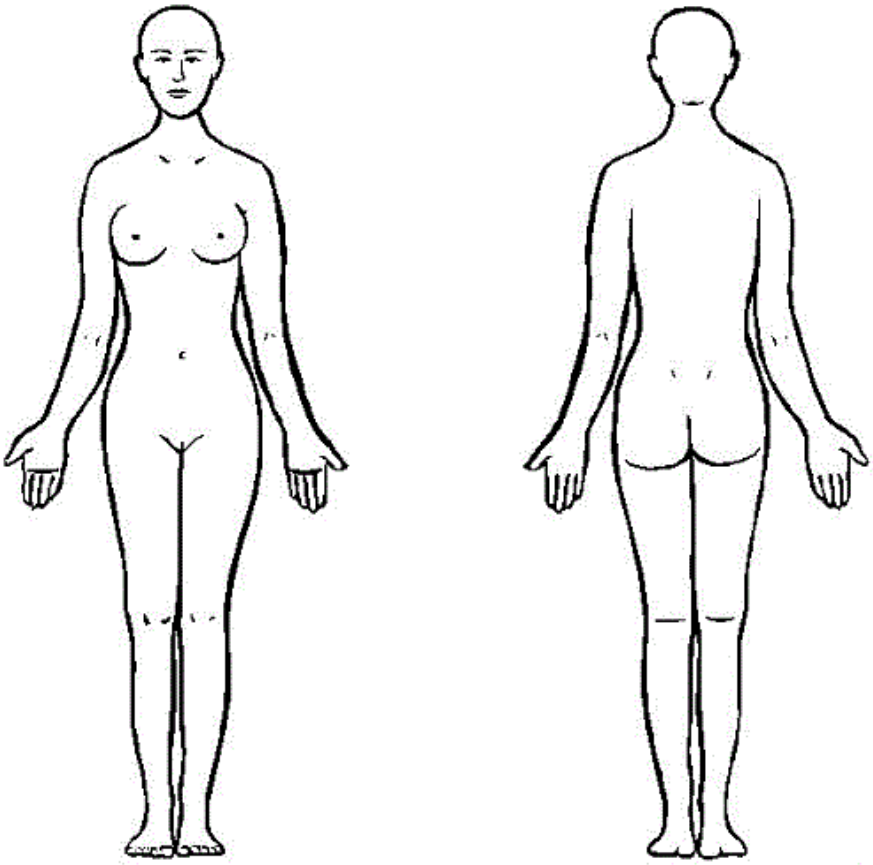
What do you do to cope with the stress in your life?

meditation and breathing

Physical and Mental Health ~~~~~~

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





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

Dr. Laura Newhouser

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.

massage therapy and acupuncture

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

you know. . .

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.

marijuana--medical marijuana…use is based on pain level and anxiety attacks

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.

recurrent severe depression; ADHD; generalized anxiety syndrome; eating disorders

Please list any prescription medications, vitamin, and/or herbal supplements you take.

I'll give you my list.

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?

Krishna spirituality

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.

Krishna

What aspects of your life are meaningful to you? my son and a great hot power yoga class!!!

What inspires you? my son

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.

Mindfulness and Meditation

Do you practice mindfulness or meditation? Yes ☒ No ☐

If yes, please briefly describe.

I practice both on a daily basis

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

Anything else?

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

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