Integral Yoga® Therapy

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 HG _____ Date March 25, 2024

Address 506 Oak Street / San Francisco, CA _____

Phone number _____ Email _____

Profession Retired _____

Pronoun(s) She / her / hers _____ Weight 120 _____ Height 5' 2" _____

Date of Birth 8/17/1953 _____ Age 70 _____

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've practiced for 20-plus years. Certified in IYI Basic & Intermediate TTs

Do you currently exercise? *Regularly* *Occasionally* *Infrequently*

Please feel free to describe what kind and how often.

Daily exercise, including workouts, hikes, yoga and Pilates

How would you describe your general health? *Great!* *Good* *Okay* *Fair* *Poor*

Do you have injuries or limitations?

I am in excellent condition

Please briefly explain any specific condition you seek to improve through Integral Yoga Therapy.

I've been diagnosed with Lumbar Anterior Spondylolisthesis (L4 & L5), Stenosis, which shows up as Sciatica.

Are you currently under the care of a doctor or other healthcare provider? *Yes* *No*

If so, please identify the provider(s):

Yes, I'm under the care of a primary care physician, an orthopedist, a PT and a chiropractor.

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?

I was diagnosed with Spondylolisthesis 8 years ago and Stenosis 10 years ago.

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.

My stress level is moderate.

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

I manage stress with Workouts, Hiking, Pilates and Yoga

Are you able to easily get up and down from the floor? Yes. *Yes* *No*

Do you feel your diet needs improvement? No. *Yes* *No*

Do you currently use tobacco products? No. *Yes* *No*

Have you ever used tobacco products? No. *Yes* *No*

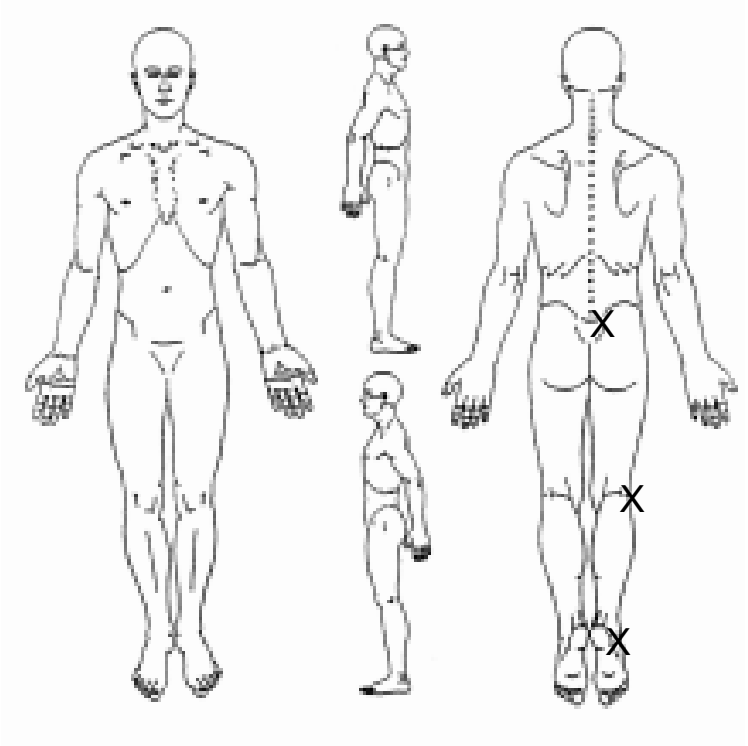
Do you inhale smoke in any form (tobacco, incense, marijuana)? No. *Yes* *No*

What is your daily alcohol intake? 2 glasses of wine / week

How would you describe your social support system? I have a strong support system.

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
2015	Sciatica	Epidural	Temporary Relief

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?)

Knees

high blood pressure

stroke history

low blood pressure, dizziness or fainting

fatigue

headaches

allergies

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

No

Other Conditions:

Sleep apnea. I use a BiPap machine to manage this.

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

HRT

Energy and Breath

What time of day do you have the most energy? *Morning* *Mid-day* *Evening* *Night*

Please share anything you'd like to tell me about your energy level

DST has been challenging. I usually get tired around 3 PM. I take 10-minute power naps to manage my fatigue.

When do you usually sleep (time asleep and time awake)?

I typically sleep from 11:30 PM to 7 AM - no waking up during the night.
I take several sleep supplements and use my BiPap machine

How would you describe the quality of your sleep? *Great* *Good* *Okay* *Fair* *Poor*

If you experience fatigue, please describe its impact, frequency, and what you do to manage it.

I take 10-minute power nap, as needed, during the day.

Do you have any breathing challenges not mentioned above?

I've been diagnosed with Apnea - a narrow airway

How would you describe your breathing?

Shallow.

Mental Health

Please list any current mental health diagnoses and treatment.

CONDITION DIAGNOSED	YEAR DIAGNOSED	CURRENT TREATMENT (Prescription, OTC, Behavioral, etc.)	CURRENT STATUS
N/A			

Please list any previous mental health diagnoses and treatment.

CONDITION DIAGNOSED	YEAR DIAGNOSED	MEDICATIONS	HOSPITALIZATONS	THERAPY
N/A				

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

N/A

If you did not include prescription or non-prescription drugs you are taking for mental health, please list and describe what they are for.

N/A

Wisdom and Intellect

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

- Friends
- Piano
- AudioBooks
- Newspaper
- Movies

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

Hike Leader / Piano / Getting back into yoga, its therapeutic applications

What would you like to learn and/or teach?

Art - sculpture & mixed media

Connection and Meaning/Purpose

Do you have a religious/spiritual orientation?

Nature.

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

Nature, my cats and family

Do you feel connected in meaningful ways?

My friends.

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

We're all here to help each other.

What, if anything, should I know about your belief system or worldview?

Everyone wants to help each other, but people hesitate.

Is there anything else you would like to share? How can we best support you?

I want to try some asanas for my back and breath practices.