VEDANTA
YOGA

Our work will be to identify and support your goals of enhancing your health and well-being through an array of science-backed, Yoga-based practices. The practices include any combination of gentle movements, dynamic stretches designed to reduce pain and improve mobility, breathing exercises, various meditation techniques, affirmations, and healthy lifestyle choices. Depending on your interests we may also use visualization, journaling, and other related techniques to support your self-discovery as well as your personal transformative and healing processes.

In all cases, the work is uniquely client-centered, and you provide input on every step of the journey. By providing the information requested on this intake form, you will help me to suggest services that will best 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. We comply with HIPAA laws; all information is strictly confidential, and nothing will be shared with a third party unless mutually agreed upon.

Name _____[redacted]_____Date _____5/9/2024_____

Address _____[redacted]_____

Phone number _____[redacted]_____ Email _____[redacted]_____

Profession _____IT Consultant_____

Pronoun(s) _____He_____Weight _____175_____Height __6’1_____

Date of Birth _____[redacted]_____ Age_____32_____

Emergency Contact _____[redacted]_____

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:

Landon Morrison - VedantaYogaLandon@gmail.com - 240 675 3427

Please circle or underline the answer most related to your response:

Are you familiar with Yoga? Yes or No? If so, what has been your experience with it?

yes - some classes, a retreat, knowledge through a friend

Do you currently exercise? Regularly Occasionally Infrequently Please feel free to describe what kind, how often, and how you feel about your exercise habits.

Yes - Regularly through squash, a home gym, or a run

How would you describe your general health? Great! Good Okay Fair Poor Do you have any injuries or physical limitations?

Great - no injuries or physical limitations

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

Focus, flexibility

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

Does this provider know you are seeking support through Yoga Therapy with Vedanta Yoga?

No

Do you have a diagnosis from a health care practitioner related to this condition? Yes No How long have you had this condition?

No

How would you rate your stress level (circle or underline)? Low Moderate High Very high

Moderate

Please feel free to describe the current sources of stress in your life.

money and house

Please describe your practices, means, and coping mechanisms for handling stress, both positive and negative, including allopathic, holistic, and/or integrative approaches.

acceptance, logical solutioning, letting it burden me down into sadness

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

Yes

Do you feel your diet needs improvement? Yes No

Yes

Do you currently use tobacco products? Yes No

No

Have you ever used tobacco products? Yes No

No

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

No

How would you describe your social support system?

Exceptional Strong Okay Marginal Poor

Strong

Do you have physical pain? If yes, please mark the places you experience pain in the images below and feel free to elaborate on them in the space provided below.

Sometimes in the fronts of my knees
sometimes in my heels
sometimes my neck

Please list any relevant medical history (serious injuries, hospitalizations, or surgeries) and/or major life events, in chronological order.

YEAR	EVENT	TREATMENT / RESPONSE	OUTCOME

Please circle or <u>underline</u> 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?)

_____

Other Conditions:

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

addiction

insomnia

nausea & indigestion

elimination problems

cancer

diabetes

are you currently pregnant?

due date

_____

Please list any other conditions not listed above that you have been diagnosed with:
no
Please list any prescription or non-prescription drugs you are taking and describe what they are for.
no

Energy and Breath: Circle or <u>underline</u> best response. Feel free to elaborate.

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.
pretty balanced throughout the day but maybe morning or evening
When do you usually sleep (time asleep and time awake)?
1030-1 – 7-830
How would you describe the quality of your sleep? Great Good Okay Fair Poor
great
If you experience fatigue, please describe its impact, frequency, and what you do to manage it.
no
Do you have any breathing challenges not mentioned above?
no
How would you describe your quality of breathing?
high

Mental Health
Please list any current mental health diagnoses and treatment:

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

Please list any previous mental health diagnoses and treatment:

CONDITION DIAGNOSED	YEAR DIAGNOSED	MEDICATIONS		HOSPITALIZATONS	THERAPY

Please feel free to explain any details about familial or personal mental health history you think I should know.
no

What goals do you have related to improving your mental health?
better introspection
understanding and empathy for others
not getting big sad from burdens
If you are taking prescription or non-prescription drugs to support your mental health, please list them and describe what they are for.
1 a day multivitamin

Wisdom and Intellect
What are the major sources of intellectual stimulation and engagement in your life now?
work, exercise/squash, reading, walks with my wife, video games with friends
What are you in the process of learning and/or teaching others?
learning squash, constantly learning at work, learning how to fix all aspects of a house
What would you like to learn and/or teach?
learn more squash
learn more bodily and mental control

Connection and Meaning/Purpose

Do you have a religious/spiritual orientation?

a connection to the universe

What connection is important for your life and health (nature, family, pets, volunteering, etc.)? Do you feel connected in meaningful ways?

nature, family, competition, friends and laughing until my mouth and head hurt

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

no

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

no

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

no