Intake Information for Spanda® Yoga Movement Therapy Practice and Practicum
Intake Basics and (non-exhaustive) Options
Practice Information, Consent and Waiver
Student Practicum Information and Consent

Intake Basics and (non-exhaustive) Options
This is a collection of intake items and item options. It is not exhaustive. When developing your client intake form consider what information will best help your assessment and design of your strategy. Also consider length of the form and client expectation. These are mediated by the impression you wish to make and your presentation of the professionalism of the developing field of yoga therapy.

CURRENT INFORMATION
- Today's Date
- Full Name
- Address
- Gender Identity
- Date of Birth/Age
- Email
- Phone
- Referred by? How find us?
- Physician
- Physician's Contact
- Emergency Contact Name and Number
- List other (healthcare or other) services you receive for this issues/condition (acupuncture, physical therapy, massage, . . .)
- Other treatments you have tried?
- Occupation
- Employer

<u>Other Options:</u>
- Ethnic/Racial Identity
- Preferred pronoun use: (s/he) (they) (other)
- What are your current religious/spiritual beliefs and practices if any? How have these been affected by current concern (if at all)?
- Have you experienced suicidal thoughts or attempted suicide? If so, please describe.
- If you woke up tomorrow living your ideal life, what would it look like?
- Describe a typical day.
- What do you like to do in your free time?
- Are there others in your life activity supporting your wellness? (exercise buddy, family member, health conscious chatgroup, etc.)

CONCERN(S)
- What is the primary concern or goal for today?
- Have you experienced this issue in the past? Describe
- Current diagnosis from a healthcare practitioner
- Describe when it began
- Is it changing? worse, better, same, intermittent

- What makes it better or worse
- How severe is it on a scale of 1-10 (10 = worst)?
- Other current concerns: complaint/since/cause if known
- Do you have any specific body discomfort? If yes, please describe
- If relevant to your visit, please circle any problem areas in the drawing and if possible, write a word to indicate the type of sensation or sensations there, such as tight, burning, numb, sharp pain, etc. (drawing of human form from four directions)
- Observations about body, energy, mental emotional life beliefs and life philosophy in relation to this concern
- What ways do you think YRx can help you?

LIFESTYLE INFORMATION

- How many hours do you work each week?
- Do you like your work?
- Does your work stress or exhaust you? (Yes/No)
- Do you generally get enough sleep?
- Living Status: (single/married/partner/divorced/widowed)
- Children:
- Are you currently, or have you recently gone through any major (or minor) life changes, or are any just ahead?
- What kind of diet do you eat? ___ Typical American ___Vegetarian___Vegan___Other:
- Do you smoke cigarettes, cigars, marijuana? (Yes/No) If yes, list
- Do you drink alcohol? (Yes/No) If yes, how many drinks per week?
- Do you use recreational drugs? (Yes/No) If yes, what and how often?
- What do you do to exercise and how often? (Ex. Walk 30 min/5 days a wk.)
- What current or part athletic, sports, dance or martial arts experience have you had?
- What is your experience with yoga, yoga therapy, meditation, other introspective, or similar eastern or wholistic practices?
- What are your biggest stressors?
- What do you do for fun and/or to relax?
- Do you sit for long hours at a workstation, computer, and/or driving?
- List allergies to medicines, foods and environmental factors:
- List prescriptions or over-the-counter medications taken regularly:
- List vitamins, minerals, herbal preparations, tonics, supplements, flower essences, cell salts, homeopathic remedies or the like taken regularly:

<u>Other Lifestyle Options and a Graded Scale</u>:

- **General Wellness Scale** 1-5 scale (5 is great!): Energy, Sleep, Digestion, Stress Management, Sense of Well-being, Positive "Can Do" attitude, Friendship(s), * Relationship with a Significant Other
- **Nutrition/Eating Habits:**
  1. Do you eat breakfast? How often? Protein in the am?
  2. Do you eat three meals a day and one snack?
  3. About how much water do you drink in a day on average?
  4. How often to do eat out or take out each week?
  5. How would you describe your overall diet?

6. Do you have a plan of eating?
7. Do you cook at home and would you like any food preparation suggestions?

- **Stress and its Mediation**
  1. Have you had a recent unusually stressful event? (Divorce, death in family, etc.)
  2. Are your finances an issue for you at this time?
  3. Are any family members an issue for you at this time?
  4. Are you worried about something: the environment, getting old, politics, etc.
  5. Are co-workers /bosses an issue for you at this time?
  6. Do you have someone/others to talk to about your feelings, concerns and frustrations?
  7. How well do you think you are able to organize your to do list?
  8. How well are you currently able to use time?
  9. Have you ever experienced and/or been treated for mental, physical or emotional abuse?
  10. How irritated are you during your day on a daily basis?
  11. Do you have a religious, spiritual, Twelve Step or other philosophy to rely upon?
  12. Do you believe in a higher power of some kind?
  13. How often do you recreate, enjoy friends and activities and have fun?
  14. What brings you joy?
  15. How often do you get out in nature?
  16. Is there a habit you would like to change? If so, what is it and what change would you make?
- **Sleep, Energy, and Breath**
  1. Do you feel like you have enough energy to do what you need and want to do?
  2. Do you have a sleep routine?
  3. Do you feel your breathing is fine or do you have any trouble with breathing?

HISTORY

- List major illnesses and hospitalizations (operations, injuries/accidents and their dates):
- Have you ever been diagnosed with any of the following? If so, what year?

___Pneumonia	___Skin boils	___Obesity	___Rheumatic fever
___Tuberculosis	___Eczema	___Anemia	___Measles
___Asthma	___Psoriasis	___Blood transfusion	___Mumps
___Bronchitis	___Parasites	___Colitis	___Chicken pox
___Emphysema	___Jaundice	___Ulcer	___Polio
___High blood pressure	___Hepatitis	___Epilepsy/Seizure	___Whooping cough
___Low blood pressure	___Gallstones	___Mental breakdown	___Diphtheria
___Heart disease	___Kidney stones	___Arthritis	__Lyme's disease
___Drug reaction	___Bladder Infection	___Cancer	___Chronic Fatigue
___Migraine	___Hypoglycemia	___Syphilis	___fibromyalgia
___Hives	___Diabetes	___Gonorrhea	___Other:

- Please list and briefly describe any conditions, medical or otherwise, that may prohibit or limit your practice of yoga stretches, movements, breathing, meditation, introspection, or relaxation
- List ailments of immediate family and indicate if deceased. Mother: Father: Siblings:
- Anything else you would like me to know?

Practice Information, Consent and Waiver

SYMT Practice Information

Spanda® Yoga Movement Therapy is dedicated to the promotion of personal growth, wellbeing, and the prevention of chronic illness and injury whenever possible. Yoga is an ancient science that may benefit a person at every level of their being. Yoga Movement Therapy utilizes the time-tested techniques, principles and practices of yoga to support and facilitate natural mechanisms of healing, improved functionality, and increased self-awareness.

Practitioner information should include your name, yoga therapist credential and any other relevant education or credentials. This is an example of practitioner information. You will write your own.

Example: Dr. Jaime Stover Schmitt is certified as a yoga therapist (C-IAYT) by the International Association of Yoga Therapists (IAYT). She has been in private yoga therapy practice since 1985 and had been teaching yoga since 1976. Dr. Schmitt has participated in the writing and revision of the Yoga Alliance Standards for the training of yoga teachers and has been training teachers since 2003. She also serves on the IAYT's accreditation committee and participates in the writing and revision of the organizations' educational standards for the practice of yoga therapy. These standards are acknowledged worldwide in the training of yoga therapists. Dr. Schmitt also holds a doctorate in education, is certified at the level of ERYT500 as a yoga teacher and is also certified as a Somatic Movement Educator, Infant Developmental Movement Educator, Swedish and Shiatsu Massage Therapist, Personal Trainer, Group Fitness Instructor, Reiki Master, and Alexander Teacher.

Fee and Billing

All sessions at this location are conducted by_____ (practitioner's name and credential)_____. The fee for the initial intake 75-minute session is $___. The fee for a 55-minute regular session is $____. Payment is due at the end of the session. Check and cash are preferred. If PayPal is used, an additional fee of $5 will be added.

_(Practitioner's name and practice name if there is one) _____ does not bill on a monthly basis and does not bill insurance companies. SMYT can provide documentation with date, fee and description of session if requested.

Cancellation Policy

There is no charge if appointments are cancelled 24 hours in advance. Cancellations within 24 hours of the scheduled time will be charged the full fee.

Consent

Informed consent means that the client is abreast of the practice they agree to partake in as offered by you, the practitioner. There are two types of consent, express consent, which is explained and agreed to, and implied consent which is assumed. Because the practice of yoga therapy is a developing complementary field and is not yet licensed, it is helpful to express consent for many items of engagement.

I, _____(print), voluntarily consent to engage in Yoga therapy and participate at my own level of comfort, knowing I can decide to discontinue at any time. I understand that Yoga therapeutic methods are based on holistic principles and practices of Yoga- its science and philosophy,

and western scientific data and are not, as yet, considered standard treatments in mainstream medicine.

During Yoga sessions, I am aware I will engage in the activities designed for my concern. I agree to take responsibility by being mindful of what I can and cannot do and to inform my yoga therapist of limitations, symptoms, pain, discomfort, or other concerns that occur or change at any point. I understand that yoga involves both cognitive and physical elements and there is inherent risk when undertaking physical activity.

I realize Yoga therapy is designed to benefit my concern, but that success is not be guaranteed. I acknowledge I must take an active role in performing the recommendations given for them to be affective.

I am aware that my Yoga therapist is not a licensed physician, that Yoga therapy is complementary to licensed healing arts, and its practices are not currently licensed. I understand the qualifications of my Yoga therapist are shown above, and that my Yoga therapist is certified by the International Association of Yoga Therapists, which is the highest level of yoga expertise for therapeutic yoga practice acknowledged worldwide.

I acknowledge that it is my responsibility to consult with my physician and obtain his or her consent prior to beginning yoga therapy. I also understand I have been advised to consult a physician for any health problems if I have not done so. It recognize it is my responsibility to ascertain that there is no medical reason preventing me from any specific practice.

I realize that touching, guiding movement, or positioning my body may be necessary and I expressly consent to such physical contact. If I do not wish to be touched, I will initial the consent form here ( ) to notify the therapist, so a joint decision can be made about continuing the practice with this limitation.

Waiver

I hereby release ____(therapist's name)_____, Spanda® Yoga Movement Therapy, and all other sponsoring agencies from responsibility for any injuries I may sustain as a result of participation in this work.

I understand that I am encouraged to ask questions and discuss my progress with the therapist at all times, and that I have read the above, understand it, and engage in this practice of my own volition.

_____ _____

(Name) (Date)

_____

(Signature)

If under 21, legal guardian's name: _____

Legal guardian's signature: _____

Student Practicum Information and Consent
These paragraphs should be included while completing practicum hours whether with another student or who individuals in your own home community.

You must provide your client information about your student practice and as if they wish to remain anonymous or if you can use their initials instead of their name in reports and supervision sessions with peers and supervisors. You must also inform your client that you are not practicing medicine, nor will you diagnose or prescribe medical treatment.

Please note: The above signature space is not needed as a student practitioner, use the one below as you will add this segment during your work in this course. It is placed above to show you where the signature and date usually occur in this document.

Yoga Therapist Practicum Student Practitioner Information
The yoga therapy session will be carried out by a student in the advanced level of the Spanda® Yoga Movement Therapist training. This means that the student working with you is not a certified by the International Association of Yoga Therapists, the standard of professional yoga therapy worldwide, and is not yet qualified to offer yoga therapy outside of this practicum experience. However, the student is closely supervised by a yoga therapist who is certified by IAYT. Yoga therapist training, while including some teaching methods, is not a yoga teacher training but a professional level therapist training using the techniques and methods of yoga science and philosophy, many of which have scientific evidence supporting their efficacy. Your case may be discussed during supervision sessions with other trainees with the faculty supervisors while your right to privacy and anonymity will be ensured.

Practicum Consent
In consideration of receiving services rendered by _____(student's name)_____ I hereby declare the student has informed be that s/he is in the advanced phase of Spanda® Yoga Movement Therapy training and is receiving supervision of her/his practice sessions. I understand that supervision includes submission of written reports and dialogue with supervisors and other yoga therapist trainees. I have been informed of my right to request the use of my initials or a pseudonym in these interactions and written documents if I choose so. Also, the student has also informed me that s/he is not licensed as a healthcare provider under the laws in this state and is not practicing medicine. S/he will neither diagnose nor prescribe for any concern.

Date: _____

Name: _____ Signature: _____

If under 21, Legal Guardian's name: _____

Signature: _____

Privacy Notice
We will go over Health Information Privacy and HIPAA Information Forms later in the training. As a student practitioner, you are not collecting payment, so while *you need to keep all information gathering confidential and stored privately,* you are not operating under HIPAA at this time.

Consent Broken Out into Ideas

- I, _____(print), voluntarily consent to engage in Yoga therapy and participate at my own level of comfort, knowing I can decide to discontinue at any time. I understand that Yoga therapeutic methods are based on holistic principles and practices of Yoga- its science and philosophy, and western scientific data and are not, as yet, considered standard treatments in mainstream medicine.

- During Yoga sessions, I am aware I will engage in the activities designed for my concern. I agree to take responsibility by being mindful of what I can and cannot do and to inform my yoga therapist of limitations, symptoms, pain, discomfort, or other concerns that occur or change at any point.

- I understand that yoga involves both cognitive and physical elements and there is inherent risk when undertaking physical activity.

- I realize Yoga therapy is designed to benefit my concern, but that success is not be guaranteed. I acknowledge I must take an active role in performing the recommendations given for them to be affective.

- I am aware that my Yoga therapist is not a licensed physician, that Yoga therapy is complementary to licensed healing arts, and its practices are not currently licensed. I understand the qualifications of my Yoga therapist are shown above, and that my Yoga therapist is certified by the International Association of Yoga Therapists, which is the highest level of yoga expertise for therapeutic yoga practice acknowledged worldwide.

- I acknowledge that it is my responsibility to consult with my physician and obtain his or her consent prior to beginning yoga therapy. I also understand I have been advised to consult a physician for any health problems if I have not done so. It recognize it is my responsibility to ascertain that there is no medical reason preventing me from any specific practice.

- I realize that touching, guiding movement, or positioning my body may be necessary and I expressly consent to such physical contact. If I do not wish to be touched, I will initial the consent form here ( ) to notify the therapist, so a joint decision can be made about continuing the practice with this limitation.

Privacy

- I understand that information obtained regarding my health or personal history will be treated as privileged and confidential by my therapist and will not be released or revealed to any person without my express consent, except as required by law. I understand that my therapist may consult with other Yoga therapists or health professionals for the purpose improving my progress, and that in so doing, my identity will not be revealed.

Waiver

- I hereby release ____(therapist's name)_____, Spanda® Yoga Movement Therapy, and all other sponsoring agencies from responsibility for any injuries I may sustain as a result of participation in this work.

Conclusion

- I understand that I am encouraged to ask questions and discuss my progress with the therapist at all times, and that I have read the above, understand it, and engage in this practice of my own volition.