



Integrated Care Concepts and Consultation

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This confidential, multi-faceted, intake form helps us understand different parts and pieces to who you are as a person. Although some questions may seem irrelevant to your care, they will play a role in our core understanding of current and past issues and help us build and develop an integrative treatment plan.

Yoga and meditation practice do not replace the care from a therapist or medical provider, but rather is used in conjunction with care you receive with these providers to enhance your well being.

Client Information

Today's Date: _____ Date of Birth: _____

Client Name: _____ Sex: M F

Address: _____ City: _____

State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ May we email you? _____

Emergency Name and Contact Number: _____

Counseling Information

Please describe the difficulties you are having that have brought you to our office: _____

What else would be helpful for us to know: _____

Employment Information

Employer: _____ Address: _____

Work Phone: _____ Occupation: _____

How would you rate your enjoyment of your job: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

What about your job do you enjoy? _____

What about your job do you dislike? _____

Family Information

Marital Status: Single Married Divorced Separated Widowed Committed-Relationship

How many people live in your household: _____ Do you live with a roommate? _____

Do you have children? _____ If so, what are your children's names and ages? _____

Health Information

Are you currently under the care of a physician for any medical issue(s), and if so, please indicate: _____

Are you currently taking any prescribed medications, and if so, what: _____

Have you ever been diagnosed with Bi-Polar Disorder? If so, when? _____

Please describe any medical conditions or situations that have had in the past: _____

Are you currently experiencing any pain in your body? _____

If so, please describe, where the pain is and the intensity: _____

What have you tried to help relieve the discomfort? _____

Is there any other health condition you would like to share? _____

How would you rate your energy level in the past 4 weeks?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How would you rate your current physical health?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How would you rate your current emotional health?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How would you rate your general happiness and wellbeing?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

In the past 4 weeks how would you rate your ability in being able to relax?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How well do you nourish yourself with healthy/balanced food?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How well do you nourish yourself with love/laughter?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How well do you nourish yourself with words of self-encouragement?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How well do you nourish yourself with self-care?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

How would you rate your current stress level?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

What would you indicate are major stressors in your life? _____

What are some ways that you have found are effective in helping you relieve stress? _____

What would you indicate is a source of comfort for you in your life: _____

What do you do to have fun? _____

What was the last book you read? _____

Who are some of your favorite musicians: _____

Do you have any difficulty falling asleep or staying asleep? _____

About how many hours of sleep do you average per night? _____

Do you awaken from sleep feeling rested? _____

Do you currently take any nutritional supplements, vitamins, herbals, essential oils: _____

Do you participate in any other type of exercise activity, and if so, what and how often? _____

Have you ever practiced Yoga? _____ If so, what style did you practice? _____

If you have practiced yoga, please describe your experience: _____

What are your goals and/or expectations in participating in a yoga and meditation practice? _____

Have you ever practiced Meditation? _____ If so, what was your experience like? _____

If not, what are the barriers preventing you from meditating? _____

How do you think meditation might help you in your life? _____

Depression/Anxiety Questions

In the past four weeks:

Have you had difficulty falling asleep or sleeping long? _____

Have you had an increase or decrease in appetite? _____

Have you had feelings of sadness, despair, sorrow? _____

Have you had excessive fatigue or lack of energy? _____

Have you had a lack of concentration or preoccupation with past or future life events?

Have you withdrawn from socialization and contact with others? _____

Have you felt a decrease in activities that were previously enjoyable? _____

Have you had thoughts that you would be better off dead or hurting yourself in some way?

Have you had feelings like you were letting yourself or others down? _____

Have you had feelings of depression or anxiety? _____

Have you had worrisome thoughts and an inability to control your worry? _____

Have you had feelings of being afraid that something tragic might happen? _____

In the past month, how often have you been completely unable to manage your days and activities due to preoccupation with these feelings of distraction? _____

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If you answered yes to any of the above questions, what have you tried to help yourself heal from these feelings? \_\_\_\_\_

What would you say is the major factor contributing to your feeling depressed or anxious?

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When feelings of depression or anxiety come over you, where do you feel it in your body?

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What do you think your body is trying to tell you? \_\_\_\_\_

**Spiritual Information**

Do you feel connected spiritually? \_\_\_\_\_

What is your spiritual practice? \_\_\_\_\_

**Referral Information**

Whom may we thank for referring you to our office: \_\_\_\_\_

Are you in our office for:      Referral      Employee Assistance Program      Insurance      Website  
Juvenile Court Referral      Psychiatrist Referral      Psychologist Referral      School Referral  
Hospital Referral      Other: \_\_\_\_\_

**Read and Sign**

We, at Integrated Care Concepts and Consultation LLC, are happy to welcome you as a participant in our class offerings. Yoga and Meditation can be a transformative practice that integrates and moves the body, mind and emotions with feelings, memories, sensations and tensions and awareness. All exercise and bodywork programs involve a risk of injury. By choosing to participate in a yoga or meditation class at Integrated Care Concepts and Consultation, LLC, you voluntarily assume a certain risk of injury. You are indicating that you have consulted with a physician for appropriate guidance in starting a new exercise program. The following guidelines will help you reduce your risk of injury:

- Listen to and follow instructions carefully
- Ask your teacher if you are unsure how to perform a certain movement if instruction is not clear
- Breathe smoothly and continuously as you move and stretch
- Do not hold your breath or strain to attain any positions
- Work gently, respect your body's ability and limits
- Do not perform movements that are painful

By signing below, you are agreeing that you have read and understand this waiver of information, and that you are voluntarily participating in an exercise, yoga, breathing activity or meditation program and that you release Integrated Care Concepts and Consultation LLC, its therapists and its teachers from any and all liability.

**Client Name/Signature/Date**

Client/Guardian Name:

Signature:

Date: