



PAUSE CENTER FOR WELLBEING

Name: _____

Pronouns: _____

Phone #: _____

Is it okay to call you? YES NO

Is it okay to text you? YES NO

Is it okay to leave a voicemail? YES NO

Email:

Is it okay to email you? YES NO

Would you like to be added to the Pause Center for Wellbeing email list? YES NO

Emergency Contact, Name: _____

Emergency Contact, Phone Number: _____

Do you actively work with a therapist? YES NO

Name of Therapist: _____

Have you ever had a PTSD assessment? YES NO

NOTE: All PTSD symptoms feel severe but this is rating the severity:

0 – 16 None, 17 – 20 None to minimum, 21 – 29 Mild, 30 – 49 Moderate, 50 – 86 Severe

If yes, do you know how your symptoms scored?

If no, how would you evaluate your own symptoms?



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What category of trauma sent your nervous system into PTSD? (ex: domestic violence, sexual assault, active shooter, veteran, first responder, witness, primary care giver, etc.)

What, if any, words would you like me to avoid using as they may cause an internal reaction? (trigger words)

How did you find the class? (Therapist, referral, friend, city registration book, other)

Do you have any concerns related to this class or is there anything else I should know?

General Information

Have you ever done **Yoga** before? _____

Have you ever **Meditated** before? _____

Do you live an **Active Lifestyle**? _____

If yes, what type of movement? _____

What causes stress in your life? _____

What do you do to relax? _____

How many hours a night do you sleep? Is it restful? _____

Do you use any recreational drugs? If yes, which ones? _____

Please list any medications and reasons for taking them: _____



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Please list any accidents or surgeries (date and description): _____

Medical conditions? _____

Do you have any concerns related to your session or is there anything else we should know?
