

**‘THE COUCH’ AND ‘YOGA WITH LISA’ PRESENT:**

**TRAUMA SENSITIVE YOGA**

**Winter Vagal Nerve Reset**

**5 WEEKS IN PERSON GROUP**

**GROUP FACILITATORS: Sara Scott and Lisa Meehan**

**Monday, 6th 13th, 20th, 27th October and 3rd November**

**Time: 7-8.30 pm**

**Where: Flow Studio, Methven**

* **Vendor: Activate Psychology**
* **Vendor Number: G09892**
* **Group based therapy triage: SCSGTT**
* **Group-based therapy: SCSGT x 10**

**Email:** [**Georgina.bathgate@gmail.com**](mailto:Georgina.bathgate@gmail.com) **for administration and to send registration forms**

[**methvenyogawithlisa@gmail.com**](mailto:methvenyogawithlisa@gmail.com) **for clinical aspects and questions**

[**sue@activatepsych.nz**](mailto:sue@activatepsych.nz) **supplier**

This form is intended to be discussed and completed together with the client and Lead Provider.

**REGISTRATION DETAILS:**

Participant Details:

|  |  |
| --- | --- |
| Name |  |
| DOB |  |
| Claim No |  |
| Phone |  |
| Address |  |
| Email |  |
| Gender |  |
| Ethnicity |  |

Lead Provider Details:

|  |  |
| --- | --- |
| Name |  |
| Phone |  |
| Email |  |
|  |  |

If the Lead Provider is planning to or must take unplanned leave during the period of this group, please provide the details of the Second Lead Provider:

Second Lead Provider Details:

|  |  |
| --- | --- |
| Name |  |
| Phone |  |
| Email |  |

Support Person (required):

|  |  |
| --- | --- |
| Name |  |
| Phone |  |
|  |  |

1. Are you able to self-regulate difficult emotions and/or will you be able to seek help from the group therapist during the process.

Yes / No

1. I have developed a safety plan with my therapist should difficult and/or distressing emotions, sensations and/or thoughts arise during or following the trauma yoga practice.

Yes / No

1. In the last 6 months have you been hospitalised due to mental health difficulties and/or had any suicide attempts? If yes, please provide details.

Yes / No

1. Do you have symptoms of dissociation? Yes / No

If yes, are you able to use coping tools to ground yourself? Yes / No

1. Have you noticed that doing certain movements or breathing exercises makes you feel uncomfortable? If yes, please provide details.

Yes / No

1. Have you previously engaged in yoga practice? Are you aware of any triggers and/or avoidance of poses or movement. Please provide details.

Yes / No

1. Do you have any injuries or medical conditions we need to be aware of? Yes / No
2. Is there anything further that you would like to share with us that might impact on your participation in this yoga practice?

Yes / No

1. I have the capacity to attend a 60-minute trauma yoga practice. Yes / No
2. Confidentiality: Disclosure or discussion of other participants is not allowed.

**Signed:** (participant name) ……………………………………….… **Date** …………….

**Signed:** (lead provider name) ………………………………………… **Date** …………….