YOGA THERAPY ASSESSMENT QUESTIONNAIRE

This a comprehensive form; a therapeutic yoga practice is designed to address your health on many levels: physical, energetic, mental, and emotional. Do your best to complete the form; please know that strict confidentiality is maintained and your answers are not shared with others.

First Name: _____Last Name: _____

Address: _____

City, State, Zip: _____ Date of Birth: ___/___/_____

Phone:_____ Email:_____

Emergency Contact: _____Relationship: _____ Phone: _____

O1) Reason for coming to take yoga therapy class?

_____

_____

O2) What do you hope to get out of group yoga therapy class(mark all that apply):

☐ Postural instruction	☐ Stress Relief	☐ Joint Health
☐ Increased Body Awareness	☐ Pain Reduction	☐ Flexibility
☐ Improved sleep	☐ Personalized practice tips	☐ Relaxation techniques

☐ Other: _____

O3) If your primary reason for the group yoga therapy class is a health-related, please indicate the current condition of your issue and the length of time you have been dealing with it (e.g. back pain, 1 year; e.g. insomnia, 5 years):

O4) Are you seeing other health professionals for your condition? If so, please describe their discipline and how often you see them (e.g. physical therapist, as needed; chiropractor, weekly)

O5) Describe your yoga practice:

a) How often do you practice yoga? _____
b) Do you have experience with meditation or other spiritual practices? _____
c) Do you experience pain or discomfort in any pose? Which one/s? _____
d) Where is the pain and when do you feel it? _____
e) Have you had any previous Yoga injuries? How did they happen? _____

GOALS

1. Identify 3 Goals you want to work on with the yoga therapist

1) _____

2) _____

3) _____

2. How important is it to you to achieve these goals?

Urgent Very Important Important Somewhat Important If it happens

3. Do you have a specific timeframe? By when do you want to achieve these goals?

_____

4. Who is supporting you in achieving these goals?

Partner [ ] Family [ ] Friends [ ] Business associates [ ] Other [ ]: _____

General Wellness Picture

Rank the following using a scale of 1-5 with 5 being the best

Energy levels	1	2	3	4	5
Sleep patterns	1	2	3	4	5
Stress Management	1	2	3	4	5
Overall feeling of wellness	1	2	3	4	5

GW 1) Do you smoke? YES _____ NO _____ If yes, how many per day?_____

GW 2) Do you consume alcohol? YES _____ NO _____ If yes, how often?_____

GW 3) Do you use recreational drugs? YES _____ NO _____

GW4) Frequency of exercise?

Daily More than 3 times a week 2-3 times a week once a week less than once a week

What type of exercise do you do?

Medical History

Please complete the following overview of your health

Do you have or have you ever had any of the following conditions: (Please Tick)

High blood pressure	☐	Glandular Fever	☐
Stroke	☐	Dizziness	☐
Asthma	☐	Lung Disease	☐
Gout	☐	Sinus Problems	☐
Heart murmur	☐	Stomach Ulcer	☐
Diabetes	☐	Arthritis	☐
Epilepsy	☐	Drug or Alcohol Problems	☐
Chrone's Disease	☐	Depression	☐
Recent weight gain/loss	☐	Thyroid Problems	☐

Do you suffer from any pain or injuries in the following areas:

Neck	☐	Back	☐
Knees	☐	Ankles	☐
Shoulders	☐	Hips	☐

Other Please specify: _____

MH1) Do you have any current diagnosis from a healthcare practitioner? YES _____ NO _____

If YES, please specify: _____

MH2) Are you currently seeing a medical practitioner for any injuries or illness? YES _____ NO _____

If YES, please specify: _____

MH3) Do you have any current medical conditions? YES _____ NO _____

If YES, please specify: _____

MH4) In the past 6-12 months, have you undergone any surgical procedures?

If YES Please specify: _____

MH4) Do you have a family history of heart disease? YES _____ NO _____

MH5) Have you ever suffered from a heart condition? YES _____ NO _____

MH6) Do you have any type of diabetes? YES _____ NO _____

MH7) Do you take any prescribed medication? If Yes, What type and why?

_____

MH8) Do you take any nutritional supplements? If yes, what type and why?

_____

MH10) Are you pregnant now or have you recently been pregnant? YES _____ NO _____

MH11) Are there any other symptoms or conditions that concern you?

Nutrition:

Question	Options	Answer
How often do you eat breakfast?	a) Every day b) Most days c) 50% of the time d)Rarely/Never	
How many meals and snacks do you eat each day?	a) + 5 b) 4-5 c) 3 d) 2 or fewer	
How much water do you drink each day?	a) 8+ cups /more than 2 litres b) 6-8 cups/ 1.5-2 litres c) 2-5 cups/ .5-1.5 litres d) 0-1 cup/ less than .5 litres	
How often do you eat take away foods	a) Rarely b) Once or twice a week c) 3-5 times a week d)+ 5 times a week	
How would you describe your overall diet?	a) restrict saturated and trans fats but eat plenty of good fats b) avoid fat as much as possible c) not concerned with fat intake and don't restrict it at all	

Stress

Question	1	2	3	4
	Always	Often	Sometimes	Never
I effectively manage to resolve issues during heavy workload periods	1	2	3	4
I get 7-8 hours of sleep at least 4 nights a week	1	2	3	4
I am satisfied with my current financial situation	1	2	3	4
I am able to control irritations in my life	1	2	3	4
I have a strong network of friends and family members	1	2	3	4
I cope with things that are outside of my control	1	2	3	4
I content with my health	1	2	3	4
I am able to speak openly about my feelings when angry or worried	1	2	3	4
I do something fun at least once a week	1	2	3	4
I organize my time effectively	1	2	3	4

SLEEP, BREATH, & ENERGY:

SB1) Describe your sleep habits;
a) Do you get enough sleep? _____
b) How many hours/night do you need to feel refreshed? _____
c) Do you wake up frequently during the night? _____
d)Do you have an established bedtime routine? _____

SB2) How would you describe your breathing patterns? Check all that apply:

- Shallow, chest breathing
- Deep and rhythmic
- I don't think about my breath
- Other: _____

SB3) How often do you spend time in nature? Check the statement that applies to you:

- Every day, I spend some time in nature
- I get out on the weekends
- I rarely get out in nature
- Other: _____

SB4) Think about self-healing tools for a moment. This could be a book that you found helpful, a magazine article, a practice, or whatever comes to mind. Then answer the following question:

a)Self-healing practices have worked in the past (check all that apply):

• Yes • No • Sometimes • Rarely • Never

b) Are there currently aspects of your life that give you joy and pleasure?

• Yes • No • Sometimes • Rarely • Never

c) Do you have a creative outlet (e.g. singing, journaling, writing, dancing, art, gardening, creative projects, etc.?)

• Yes • No • Sometimes • Rarely • Never

SB5) Do any of the following statements apply to you (please mark the ones that apply):

- I believe that most of life's daily challenges can be overcome
- I believe that life is hard and survival is a struggle
- I'm just waiting for the next big issue to come up and wear me down
- IN YOUR OWN WORDS, I believe: _____

SB6) Are you conscious of a higher purpose or meaning of your life?

• Yes • No • Sometimes • Rarely • Never

SB7) If you could change just one of your habits, what would that be?

Do you have any movement restriction to be respected? YES_____ NO_____

Please circle your problem areas in the drawing and indicate the symptoms with these symbols:

Tension: ----------
Cramping: //////////
Numbness: +++++++
Pain: >>>>>>>>

symptoms: location/intensity/duration/frequency/onset