Yoga as Therapy Questionnaire

Please answer the questions below in your own words as you understand them.

If you can't answer a question, please state "don't understand" or "don't know" as appropriate.

Name

Date of birth

How much and what type exercise do you do?

Have you done yoga before? (Y/N)

If so please elaborate. For example how much, how often, how long ago and what kind of yoga you've done

MEDICAL STATUS

Have you needed to see your GP in the last 12 months? (Y/N)

If so, please describe what your complaint was

Have you been receiving treatment or taken any medication in the last 12 months? (Y/N)

If so, please give details

Have you undergone any medical investigation in the last 12 months

If so, please give details

Are you aware of suffering or having suffered from any of the following?

Neck pain (Y/N)

Please elaborate in your own words

Back pain (Y/N)

Please elaborate in your own words

Headache (Y/N)

Please elaborate in your own words

Migraine (Y/N)

Please elaborate in your own words

Other pain (anywhere) (Y/N)

Please elaborate in your own words

High blood pressure (Y/N)

Circulatory disturbance such as swelling or varicose veins (Y/N)

Please elaborate in your own words

Heart complaints (Y/N)

Please elaborate in your own words

Respiratory complaints (Eg wheezing, cough, pain on breathing) (Y/N)

Please elaborate in your own words

Disturbance or changes in bladder habit (Y/N)

Please elaborate in your own words

Disturbance or changes in bowel habit (Y/N)

Please elaborate in your own words

Digestive complaints (Eg. Indigestion, acid reflux, etc) (Y/N)

Please elaborate in your own words

Skin, nail or hair changes (Y/N)

Please elaborate in your own words

Changes in hearing, sight, taste, smell (Y/N)

Please elaborate in your own words

Sore or dry eyes, mouth (Y/N)

Please elaborate in your own words

Disturbance in balance (Y/N)

Please elaborate in your own words

Numbness, reduced sensation or pins and needles in the extremities or face (Y/N)

Please elaborate in your own words

Muscular weakness or disturbance in mobility and co-ordination (Y/N)

Please elaborate in your own words

Changes in weight over the last 12 months (Y/N)

Please elaborate in your own words

Loss of energy (Y/N)

Please elaborate in your own words

Difficulty with sleep (Y/N)

Please elaborate in your own words

Depression (Y/N)

Please elaborate in your own words

Have you had any surgery? (Y/N)

Please give details and approximate dates

Have you suffered any significant accident or physical injury? (Y/N)

Please give details and approximate dates

Please feel free to write down anything you feel was not covered in the above questionnaire

WOMEN:

What is your menstrual status? Eg. Still menstruating, menopausal, post-menopausal, etc.

Do you have children? (Y/N)

If so how many and what are their ages?

ARE YOU EXPERIENCING

Disturbance or changes in your menstrual cycle (Y/N)

Please elaborate in your own words

Other gynaecological disturbance (Y/N)

Please elaborate in your own words

Have you had a bone density test? (Y/N)

If so, what are the results?