Kripa Foundation Iyengar Yoga™ as Therapeutic Exercise – Pre Therapy Survey

This survey will provide your yoga studio with information about your health so that your therapy can be individually tailored to your needs. The survey will be used to both track your improvement overtime and to inform modifications to your yoga therapy sequence as needed. This survey should take 30-40 minutes to complete. Your certified Iyengar yoga teacher (CIYT) will review your responses and schedule your first meeting. Please also contact your CIYT if any questions arise during this process.

Email

_____

Please enter your student ID. Your student ID is your first, middle, and last initials, followed by the last two digits of your birth year, followed by the name of the city you live in (no spaces), followed by the abbreviation of your country. Example: John Tom Smith born in 1956 living in Los Angeles. Student ID is JTS56LosAngelesUS.

_____

What is your current age?

_____

What is your occupation?

_____

Are you a new Iyengar yoga student?

- ○ Yes
- ○ No

Do you practice Iyengar Yoga?

- ○ Yes
- ○ No

If yes, how often? (How many days per week?)

_____

For how long?

- ○ 15 min
- ○ 30 min
- ○ 1 hour
- ○ Other _____

How many years/months have you practiced Iyengar Yoga?

_____

How many years/months have you practiced other forms of yoga? (Please describe)

_____

_____

In the past 7 days, how many days have you practiced yoga?

- Every day (100%)
- Most days (75%)
- About 3-4 days (50%)
- A few days (25%)
- None (0%)
- Other _____

On average, each time you practice yoga how many minutes are you practicing?

_____

Please list the name of the Iyengar yoga therapy teacher you will be working with (if known)

_____

Please list the name of the yoga studio you will be doing Iyengar yoga therapy at (if applicable):

_____

Please list the approximate date you will be starting your Iyengar yoga therapy

_____

Please check all areas of concern regarding your health

- Allergies
- Asthma
- Ankles/Feet
- Anxiety
- Arthritis
- Auto-immune Dysfunction
- Bladder
- Brain
- Carpal Tunnel
- Cancer
- Chronic Fatigue
- Diabetes
- Depression
- Dizziness
- Eyes
- Gastrointestinal Disorder
- Headache
- Heart Condition
- Heel Spur
- High Blood Pressure
- Hips/Legs
- HIV-related
- Hypoglycemia
- Insomnia
- Kidney
- Knees
- Liver
- Lower Back
- Low Blood Pressure
- Menopause
- Menstrual Problems
- Multiple Sclerosis
- Neck
- Osteoporosis
- Plantar Fasciitis
- Pregnancy
- Post-Partum
- Prolonged illness
- Prostate
- Recent Surgery
- Sedentary Lifestyle
- Sciatica

- Scoliosis
- Shoulders
- Thyroid
- Upper Back
- Wrist/Hand
- Other _____

Please list your top concern/complaint

_____

Please describe your conditions in detail (including diagnosis if applicable)

_____

_____

_____

_____

_____

Have you ever been in a car accident or had a traumatic injury? If yes, please list the year of this injury and describe the resulting injuries:

_____

_____

_____

Please select any of the following treatments that you have previously used or are currently using:

- Physical Therapy
- Psychotherapy
- Chiropractic
- Massage
- Acupuncture
- Deep Tissue Therapy
- Homeopathic Medicine
- Other _____

Please list any medications or supplements that you are currently taking with dosage. Please include any over the counter medication as well as vitamins. (Examples: 0.3 mg of melatonin nightly; 20 mg Lisinopril daily; Estradiol (oral 1mg/day))

_____

_____

_____

_____

Gender: How do you identify?

- ○ Female
- ○ Male
- ○ MTF Female
- ○ FTM Male
- ○ Intersex
- ○ Prefer not to say
- ○ Other_____

What is your ethnicity/race? (Please select all that apply)

- ○ American Native Indian or Alaskan Native
- ○ Asian
- ○ Black
- ○ Native Hawaiian/Pacific Islander
- ○ White/Caucasian
- ○ Hispanic/Latino/a/ex
- ○ Arab/Middle Eastern
- ○ Other_____

In general, how would you rate your physical health? (1 being Poor, 5 being Excellent)

- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5

To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

- ○ Completely
- ○ Mostly

- ○ Moderately
- ○ A little
- ○ Not at all

In the past 7 days, how would you rate your pain on average?
(0 being no pain, 10 being worst imaginable pain)

- ○ 0
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10

In the past 7 days, how often did you have pain so bad that you could not do anything for the whole day?

- ○ Never
- ○ Rarely
- ○ Sometimes
- ○ Often
- ○ Always

In the past 7 days, how often did you have pain so bad that you could not get out of bed?

- ○ Never
- ○ Rarely
- ○ Sometimes
- ○ Often
- ○ Always

In the past 7 days, how often did you have very severe pain?

- ○ Never
- ○ Rarely
- ○ Sometimes
- ○ Often
- ○ Always

In the past 7 days, how often did you have pain so bad that you had to stop what you were doing?

- ○ Never

- Rarely
- Sometimes
- Often
- Always

In the past 7 days, how often did you have pain so bad that it was hard to finish what you were doing?

- Never
- Rarely
- Sometimes
- Often
- Always

Are you able to do chores such as vacuuming or yard work?

- Without any difficulty
- With a little difficulty
- With some difficulty
- With much difficulty
- Unable to do

Are you able to go up and down stairs at a normal pace?

- Without any difficulty
- With a little difficulty
- With some difficulty
- With much difficulty
- Unable to do

Are you able to go for a walk of at least 15 minutes?

- Without any difficulty
- With a little difficulty
- With some difficulty
- With much difficulty
- Unable to do

Are you able to run errands and shop?

- Without any difficulty
- With a little difficulty
- With some difficulty
- With much difficulty
- Unable to do

Does your health now limit you in doing two hours of physical labor?

- Not at all
- Very little

- Somewhat
- Quite a lot
- Cannot do

Does your health now limit you in doing moderate work around the house like vacuuming, sweeping floor or carrying in groceries?

- Not at all
- Very little
- Somewhat
- Quite a lot
- Cannot do

Does your health now limit you in lifting or carrying groceries?

- Not at all
- Very little
- Somewhat
- Quite a lot
- Cannot do

Does your health now limit you in doing heavy work around the house like scrubbing floors, or lifting or moving heavy furniture?

- Not at all
- Very little
- Somewhat
- Quite a lot
- Cannot do

I can manage my symptoms during my daily activities

- I am not at all confident
- I am a little confident
- I am somewhat confident
- I am quite confident
- I am very confident

I can keep my symptoms from interfering with relationships with friends and family

- I am not at all confident
- I am a little confident
- I am somewhat confident
- I am quite confident
- I am very confident

I can manage my symptoms in a public place

- I am not at all confident

- I am a little confident
- I am somewhat confident
- I am quite confident
- I am very confident

I can work with my doctor to manage my symptoms

- I am not at all confident
- I am a little confident
- I am somewhat confident
- I am quite confident
- I am very confident

In the past 30 days, how much did you rely on others to take care of you because of your health?

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

In the past 30 days, how often did your health slow you down?

- Never
- Rarely
- Sometimes
- Often
- Always

In the past 30 days, how often did your health make it hard for you to do things?

- Never
- Rarely
- Sometimes
- Often
- Always

In the past 30 days, how often did your health keep you from going out?

- Never
- Rarely
- Sometimes
- Often
- Always

In the past 30 days, how much did your health make it hard for you to do things with your friends?

- ○ Not at all
- ○ A little bit
- ○ Somewhat
- ○ Quite a bit
- ○ Very much

In the past 7 days, I felt worthless
- ○ Never
- ○ Rarely
- ○ Sometimes
- ○ Often
- ○ Always

In the past 7 days, I felt helpless
- ○ Never
- ○ Rarely
- ○ Sometimes
- ○ Often
- ○ Always

In the past 7 days, I felt depressed
- ○ Never
- ○ Rarely
- ○ Sometimes
- ○ Often
- ○ Always

In the past 7 days, I felt hopeless
- ○ Never
- ○ Rarely
- ○ Sometimes
- ○ Often
- ○ Always

In the past 7 days, I felt fearful
- ○ Never
- ○ Rarely
- ○ Sometimes
- ○ Often
- ○ Always

In the past 7 days, I found it hard to focus on anything other than my anxiety
- ○ Never

- Rarely
- Sometimes
- Often
- Always

In the past 7 days, my worries overwhelmed me
- Never
- Rarely
- Sometimes
- Often
- Always

In the past 7 days, I felt uneasy
- Never
- Rarely
- Sometimes
- Often
- Always

I felt left out
- Never
- Rarely
- Sometimes
- Often
- Always

I feel that people barely know me
- Never
- Rarely
- Sometimes
- Often
- Always

I feel isolated from others
- Never
- Rarely
- Sometimes
- Often
- Always

I feel that people are around me but not with me
- Never
- Rarely

- Sometimes
- Often
- Always

In the past 7 days, my sleep quality was
- Never
- Rarely
- Sometimes
- Often
- Always

In the past 7 day, my sleep was refreshing
- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

In the past 7 days, I had a problem with my sleep
- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

In the past 7 days, I had difficulty falling asleep
- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

During the past 7 days, I felt fatigued
- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

During the past 7 days, I have trouble starting things because I am tired
- Not at all
- A little bit
- Somewhat

- Quite a bit
- Very much

In the past 7 days, how run-down do you feel on average

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

How fatigued were you on average?

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much