DEPARTMENT OF Wellness
Striving to be America's HEALTHIEST Campus

Date: ___/___/___

YOGA THERAPY 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:_____ CWID:_____

Affiliation: ☐ Undergrad ☐ Graduate/Doctorate ☐ Faculty/Staff ☐ Alumni ☐ Other: _____

Emergency Contact: _____Relationship: _____ Phone: _____

1. What do you hope to get out of your personal Yoga session (mark all that apply):

☐ Postural instruction ☐ Stress Relief ☐ Joint Health
☐ Increased Body Awareness ☐ Pain Reduction ☐ Flexibility
☐ Improved sleep ☐ Personalized practice tips
☐ Other: _____

Please indicate your preferred time to meet:

Preferred Times/Days	Morning 9:00-12:00	Noon 12:00	Afternoon 1:30-5:00	Early Evening 5:30-7:00	Evening 7:00-9:00
MONDAY					
TUESDAY					
WEDNESDAY					
THURSDAY					
FRIDAY					
SATURDAY					

HEALTH HISTORY:

2. Please list your current and previous health conditions. Please list medical diagnoses, surgeries, accidents, and/or injuries followed by the approximate date:

3. Are there any other health problems or life challenges that you wish to share?

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

Date: ___/___/___

5. 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)

6. Please list your current medications, including supplements:

7. Please state the areas of your body where you are experiencing discomfort. Describe where the discomfort is located and the type and degree of discomfort; level 1 being little pain, and 10 being severe pain (e.g. throbbing knee pain, level 5).

8. What relieves your pain? What increases your pain? This could be a movement, a yoga posture, or other. (Example: Knee pain increased by descending stairs; decreased when joint is resting).

LIFESTYLE, PERSONAL WELLNESS, AND STRESS:

9. Describe your lifestyle.

- Do you watch what you eat? ☐Always ☐Sometimes ☐Rarely ☐Never
- How often do you exercise and what kind of exercise do you do? _____ _____
- Do you smoke? ☐Yes ☐No If yes, frequency:_____
- Do you drink? ☐Yes ☐No If yes, frequency:_____

10. In a few words, describe your typical diet.

11. In percentages, please indicate how much of your day you are in the following positions:

Sitting: _____% Standing: _____% Lifting: _____%
Driving: _____% Computer or desk work: _____% Lying down: _____%

12. What areas of your life are challenging or stressful? Check all that apply:

☐ **Personal** ☐ **Work** ☐ **Family** ☐ **Other**

13. What is your CURRENT perceived stress level – low, moderate, or high?

☐ Low ☐ Moderate ☐ High

14. Do your self-help methods help you deal with stressful situations?

☐ Yes ☐ No ☐ Sometimes

SLEEP, BREATH, & ENERGY:

15. Describe your sleep habits; for example:

- ☐ **Do you get enough sleep? _____**
- ☐ **How many hours/night do you need to feel refreshed? _____**
- ☐ **Do you wake up frequently during the night? _____**
- ☐ **Do you have an established bedtime routine? _____**

16. 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: _____**

17. 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: _____**

LIFE TOOLS & RESOURCES:

18. 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:

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

☐ Yes ☐ No ☐ Sometimes ☐ Rarely ☐ Never

19. Are there currently aspects of your life that give you joy and pleasure?

☐ Yes ☐ No ☐ Sometimes ☐ Rarely ☐ Never

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

☐ Yes ☐ No ☐ Sometimes ☐ Rarely ☐ Never

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21. 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: _____**

22. Are you conscious of a higher purpose or meaning of your life?

☐ **Yes** ☐ **No** ☐ **Sometimes** ☐ **Rarely** ☐ **Never**

23. If you could change just one of your habits, what would that be?

YOGA HISTORY (PLEASE COMPLETE IF YOU HAVE EXPERIENCE WITH YOGA)

- **What is your experience with Yoga, meditation or other spiritual practices?**
- **How often do you practice and is your practice regular?**
- **Do you experience pain or discomfort in any pose? Which one/s?**
- **Where is the pain and when do you feel it?**
- **Have you had any previous Yoga injuries? How did they happen?**

RELEASE AND INDEMNITY AGREEMENT: I hereby release the Board of Regents of Oklahoma State University and all its employees from all claims that may be sustained while attending this session, and I agree to indemnify the Board of Regents of Oklahoma State University and its employees for any claim which may hereafter be presented as a result of such injuries.

Print Name _____

Signature _____**Date**_____

Please return form to:

Dr. Carol Bender
Yoga Therapist & Wellness Instructor
Email: carol.bender@okstate.edu
Phone or text message: (405) 747-9826