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Therapeutic Yoga

Pain & stress reduction

Yoga of Recovery

Ayurveda & Yoga
Lifestyle Counseling

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QUESTIONNAIRE

Date _____

Name _____

Home Address _____

City _____ State _____ Zip _____

Email _____

Home Phone _____ Cell _____

Male/Female ____ Date of Birth _____ Age _____ Marital Status _____

Work Address _____

City _____ State _____ Zip _____

Work Phone _____ Extension _____

Occupation _____

Emergency Contact _____

Phone _____ Relation _____

How did you find out about us? _____

Do you have a diagnosis by a physician? If so, please describe: _____

_____

_____

_____

_____

Are you taking any medication at this time?

◯ Yes ◯ No If so, please explain: _____

_____

Is there any time of day or night that you always experience pain or discomfort?

◯ Yes ◯ No If so, please explain briefly: _____

_____

_____

Questionnaire continued:

Circle the letter(s) of the area(s) of your life with which the pain or discomfort has interfered:

a. work **b.** social activities **c.** emotional well-being **d.** sex life **e.** family responsibilities

f. other _____

What type of exercise or physical activities do you participate in, and with what frequency?

_____

_____

_____

On a scale of 0 to 5 (zero = none; five = high) how would you rate your daily stress level? _____

Please briefly describe it: _____

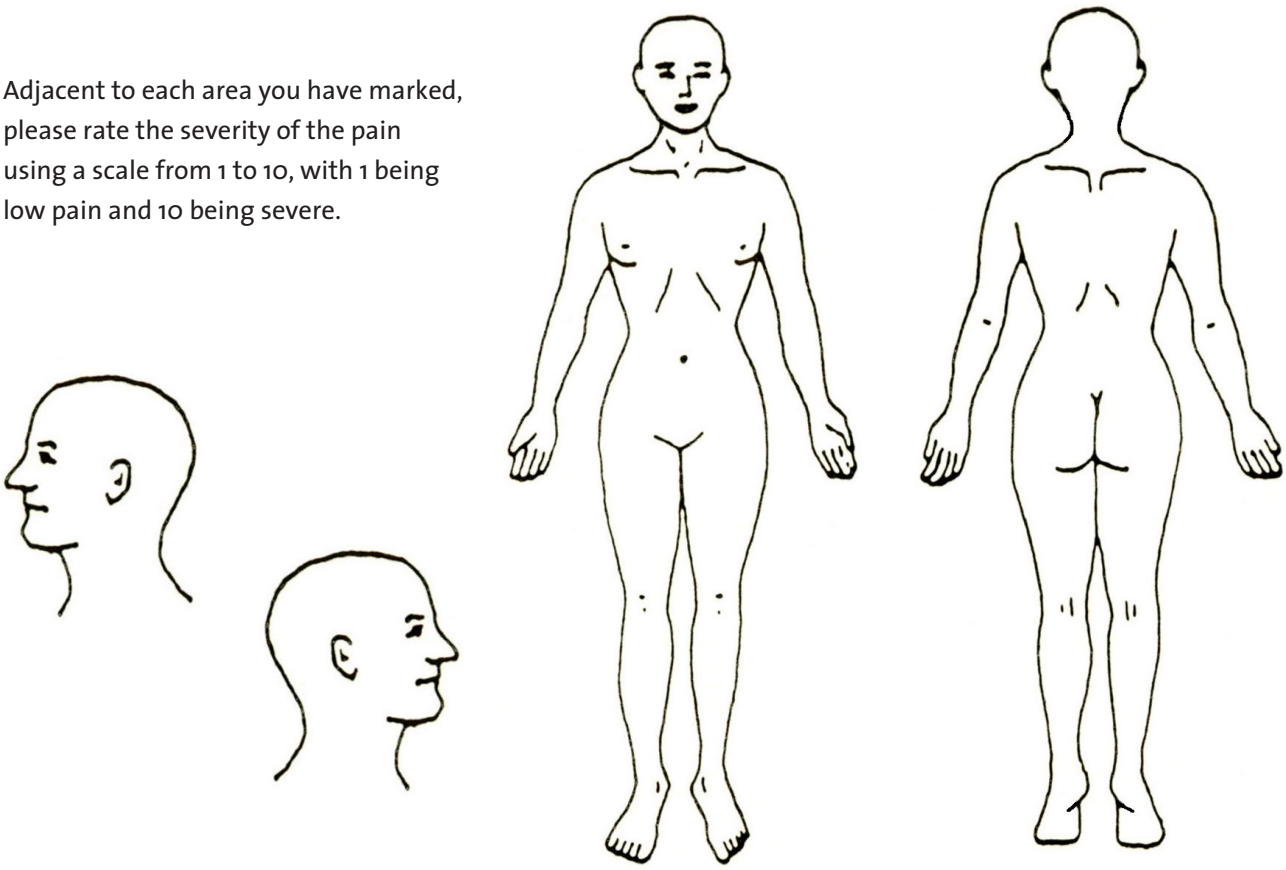
_____

_____

Directions: Please place these symbols on the diagrams below to indicate the location and type of pain you experience:

////	sharp pain	XXXX	burning, radiating pain
====	numbness	OOOO	dull ache

Adjacent to each area you have marked, please rate the severity of the pain using a scale from 1 to 10, with 1 being low pain and 10 being severe.



What do you do to feel better when you are in pain? _____

_____

What makes the pain worse? _____

_____

What health professionals have helped you the most?

NAME TITLE CITY WHERE LOCATED

_____

_____