Essential Yoga Therapy

Please complete the questions below as accurately as possible so that your practitioner can assist you with your individual condition.

Name: _____ Contact Number: _____

Parent's name (if applicable) _____ Email address: _____

Occupation: _____ Does it require much TALKING or PHYSICAL EXERCISE? (Circle)

Please give additional details if appropriate: _____

What condition / symptoms do you have? 1) _____2) _____

When were you first diagnosed with your condition? _____ (years)

Please state which best describes your condition:

Sometimes have symptoms: □ Continuous symptoms (mild): □

Continuous Symptoms (moderate): □ Continuous symptoms (severe): □

How often have you been admitted to hospital for asthma attacks/or other, in the past three years?

Do you feel that deep breathing is good for you? YES / NO

Please circle answer:

Do you feel stressed, anxious regarding your condition?	**Never**	**Sometimes**	**Often**	**Very Often**
Is your nose blocked?	**Never**	**Sometimes**	**Often**	**Very Often**
Do you breathe through your mouth during the day?	**Never**	**Sometimes**	**Often**	**Very Often**

Do you breathe through your mouth during the night? (Do you wake up with a dry mouth?)	**Never**	**Sometimes**	**Often**	**Very Often**

Have you completed a Sleep Study? YES / NO If yes, give approximate date: _____

Have you been prescribed a CPAP machine? YES/ NO Do you currently use it? YES / NO

Do you Smoke? YES / NO IF yes, how many cigarettes a day: _____

How many glasses of pure water do you drink each day (approx.)? _____

Do you limit your intake of dairy foods? YES/NO Has this helped you? YES/NO

How many hours a week do you partake in physical exercise?	Less than one hour	1-2 hours	2-3 hours	3-4 hours	4-5 hours	5-6 hours	6-7 hours	7 or more

Please indicate √ the level of severity of any of the symptoms that you experience in list below:

1 = Mild, 2 = Moderate, 3 = Severe

Complaint	**1**	**2**	**3**		**Complaint**	**1**	**2**	**3**
Coughing					Excessive sweating			
Wheezing					Cold hands / feet			
Chest Tightness					Tummy upset / IBS			
Exercise Induced Asthma					Achy Muscles			
Frequent Colds					Tiredness			
Breathlessness at rest					Insomnia /Broken Sleep			
Frequent Sighs					Poor Concentration			
Frequent Yawning					Racing Mind			
Feeling Short of Breath					High Perceived Stress			
Palpitations					Feeling of Anxiety			
Erratic/Faster Heart Beat					Panic Attacks			
Sleep Apnoea					Headaches			
Snoring					Crooked Teeth			

Faster or Deeper Breathing					Light headedness			
Dizzy Spells					Tight Jaw or Throat			
Visual Disturbances					Go to bathroom during night			
Chest Wall Pains					Bloated Feelings in Stomach			
Feeling Tense					Unable to Breathe Deeply			

Please indicate any other common symptoms that you may experience: _____

Please list Asthma medications you take:

Preventer: _____ Daily Dose:_____

Reliever: _____ Daily Dose:_____

List any other illness you have: _____ Medication:_____

Please indicate if you have any concerns: _____

_____

How did you hear about this course: (Please circle)

Social Media	Friend	Newspaper	GP or Consultant	Internet Search	Radio	Health Care Practitioner	Other:

For Female participants: Please tell the practitioner if you are currently pregnant.

Disclaimer: you are requested to read the following carefully and to follow the instructions.

I,_____ agree not to decrease or alter my medication without prior consultation and approval from a Medical Doctor. I confirm that I have read and fully understand that failing to comply with this direction may pose a risk to my health and that it would be against the recommendations of Robin Rothenberg.

Signed: Date:

In the event of a participant is under 18 years of age, this disclaimer must be signed by a parent or legal guardian.