Research

Characteristics of Clients Seeking Yoga Therapy in a University-Based Student Clinic

Steffany Moonaz, PhD, C-IAYT,1 Marlysa Sullivan, PT, C-IAYT,1 Daryl Nault, MS,1 Irene Bright-Dumm, MS,1 Ryan Bradley, ND, MPH2

1. Maryland University of Integrative Health, Laurel, Md.
2. Helfgott Research Institute, National University of Natural Medicine, Portland Ore.; Division of Preventive Medicine, University of California, San Diego, Calif.; and Australian Research Centre of Complementary and Integrative Medicine, Faculty of Health, University of Technology Sydney, Ultimo, New South Wales, Australia.

Correspondence: smoonaz@muih.edu

Abstract

Yoga therapy is an emerging profession with recent development of educational competencies, training program accreditation, and practitioner certification. In the United States, most yoga therapy training programs are studio-based and data on mentored clinical encounters are lacking. This study aimed to characterize the client population in a university-based mentored student clinic. As part of a larger feasibility study, data were collected from all clinic visits for 70 consenting clients. Data collected included demographic characteristics, reasons for pursuing care, use of other healthcare approaches, and the Patient-Reported Outcomes Measurement Information System (PROMIS) for physical and mental health. Participants were mostly middle-aged, White, and highly educated. Common reasons for pursuing care were pain and mental health. Most used multiple healthcare approaches. Average scores for most patient-reported outcomes fell within normal range at baseline. Future studies are needed to better characterize yoga therapy users and to expand access for populations in whom the modality is underutilized despite emerging evidence of relevance. Moonaz et al. Int J Yoga Therapy 2021(31). doi: 10.17761/2021-D-20-00003.

Keywords: yoga therapy, chronic pain, mental health, demographic characteristics, PROMIS, patient-reported outcomes, integrative health

Background

Yoga is an ancient system of philosophy and practices intended to help alleviate suffering.1-3 It consists of physical postures and movement, breath techniques, meditation, and lifestyle strategies including ethical inquiry.4 Yoga has become popular in the United States, with reported use by more than 36 million practitioners.5 In addition, yoga is the most commonly sought complementary health approach among U.S. adults, increasing from 9.5% in 2012 to 14.3% in 2017, according to the National Health Interview Survey.6 Importantly, the health conditions for which a growing body of research supports yoga’s efficacy closely parallel the top reasons people seek complementary and integrative health (CIH) practices generally: back pain (17.1%), neck pain (5.9%), joint pain (5.2%), arthritis (3.5%), and anxiety (2.8%).6,7 However, there are significant barriers to yoga practice including access, time, and out-of-pocket costs.6 Additionally, both CIH and yoga uptake in the United States are primarily seen in non-Hispanic, White women with a college degree or higher and aged 18–44.6,8-9 Although disparities are decreasing, yoga practices remain less accessible to and underutilized by diverse, under-resourced, and less-educated communities.6-9 It is thus essential to improve yoga’s accessibility and acceptability for diverse populations to improve its uptake as a cost-effective therapeutic intervention strategy. One possible contributor to this disparity may be the underutilization of referrals to yoga by health professionals.10 Referrals to yoga by medical professionals appear to depend on the level of the professional’s personal yoga practice rather than on any evidence-based guideline or knowledge of its benefit as a viable intervention strategy.10 Greater education for medical and...
healthcare professionals as to the benefits of yoga for various patient populations might facilitate greater uptake of this practice as a therapeutic intervention for diverse populations.

Concurrent with increased public utilization of and interest in yoga has been a threefold increase in published yoga research from 2003–2013, compared to 1967–2003. For many years, the top conditions discussed in the research were mental health, cardiovascular disease, and respiratory disease. Newer research is exploring yoga as a complementary practice for a wider array of health conditions including, but not limited to, menopause, breast cancer survivor wellness, type II diabetes, irritable bowel syndrome, low back pain, anxiety, depression, arthritis, asthma, epilepsy, hypertension, posttraumatic stress disorder (PTSD), and pain. One overview of systematic reviews found positive and promising outcomes in the literature for yoga as a complementary practice for fibromyalgia symptoms, pain management, anxiety, and quality of life for cancer patients. In particular, yoga shows promise for the management of low back pain. This growing body of research demonstrates yoga’s potential as part of self-care in complex chronic conditions.

Overlapping with several of the aforementioned conditions, physical health concerns are often reported as the reason(s) for the initiation of yoga practice. However, continued adherence and motivation for practice often shift to psychoemotional and spiritual reasons. Both the variety in perceived health benefits and motivations for continued use may contribute to yoga’s popularity and support the need for continued research into the specific benefits of yoga to support health and well-being.

The application of yoga to clinical challenges has contributed to the growth of yoga therapy, a field distinct from yoga teaching. The International Association of Yoga Therapists (IAYT) describes yoga therapy as “the professional application of the principles and practices of yoga to promote health and well-being within a therapeutic relationship that includes personalized assessment, goal setting, lifestyle management, and yoga practices for individuals or small groups.” Yoga therapy includes an assessment of the individual and delivery of yoga practices (e.g., movement, breathwork, meditation, and lifestyle guidance) in a manner specifically tailored to the client’s multidimensional health goals and taking into consideration any medical diagnoses and treatments. In contrast to the 1,000 or more hours of training received by IAYT-certified yoga therapists (CIAYTs) for working therapeutically with diverse health needs and challenges, general yoga classes are taught by teachers who usually have a minimum of 200 hours of teacher training with no specific education on assessment or application for therapeutic intentions. Additionally, yoga teachers may or may not be educated on understanding health conditions and appropriate modifications of yoga practice.

Until now, research has not distinguished between yoga and yoga therapy. This lack of clarity, combined with the increase in utilization and the growing professionalization of the field, calls for further exploration of the differences between yoga and yoga therapy. Studying the characteristics of those seeking yoga therapy will help to define the field, explore the needs of those seeking this intervention, and identify populations that could benefit but are not currently accessing this service. In response to these needs, this study aimed to test the feasibility of research data collection in a student clinic and explored the characteristics of clients seeking yoga therapy in an outpatient, academic clinical setting.

**Methods**

Maryland University of Integrative Health (MUIH) provides a Master of Science in Yoga Therapy degree that includes a faculty-supervised student clinic in the university’s Natural Care Center (NCC) in the second year of the program. All faculty supervisors are CIAYTs. These clinical visits are open to the public and available at a reduced cost compared to private yoga therapy.

Informed consent was sought from all new yoga therapy clients presenting to the MUIH NCC from June 2017 through October 2018. Clients were eligible if they were new to the NCC yoga therapy clinic and had not previously received yoga therapy. An “opt-out” form was provided along with the paperwork for the initial clinic visit. Clients could check the box on the opt-out form if they did not want to hear about the study. If the opt-out box was not checked, study staff entered the clinic room to inform the client of the study and engage in a consent process. This enrollment process occurred for interested clients during a natural pause in the clinic session, after the student’s initial assessment, when the student left the room to consult with a faculty member regarding the care plan. Baseline data were collected prior to yoga therapy care. Follow-up data were collected prior to care during any subsequent visits that occurred during the study period.

After signing the informed consent document, enrolled participants completed all forms on a Microsoft Surface Pro 5 electronic tablet using a Research Electronic Data Capture (REDCap)-based platform to directly enter demographic characteristics and clinical concerns (intake). Participants then completed the Patient-Reported Outcomes Measurement Information System (PROMIS) v.1.0 Computer Adaptive Tests (CAT), a health-related quality of life instrument that includes seven domains: Pain Intensity, Anxiety, Depression, Pain Interference, Physical Function,
Self-Efficacy for Symptom Management, and Sleep Disturbance. PROMIS is well-validated across multiple clinical conditions, including several pain (e.g., low back pain and rheumatoid arthritis) and mental health conditions (e.g., depression). The intake form was developed based on revision of a prior survey to report characteristics of yoga therapists, relying on U.S. Census and other standard categories when possible, which was then pilot-tested for clarity and ease of use. For the Physical Function and Self-Efficacy scales, a higher score indicates better/improved function or efficacy, or patient-provider connection, respectively. The reverse is true for the PROMIS Anxiety, Depression, Pain Interference, Pain Intensity, and Sleep Disturbance domains, where a higher score indicates worsening/more of the condition represented.

In November 2017, there was a pause in recruitment due to technological challenges and long delays in loading the PROMIS-29 v1.0 CAT form that impacted clinical care. Recruitment restarted with the next student cohort in October 2018. After this pause, the study enrollment and baseline data collection were moved to take place earlier in the visit, after initial paperwork was completed but before the student’s initial assessment to reduce interference with clinical care. The initial research proposal and all subsequent protocol changes were approved and overseen by the MUIH Institutional Review Board (approval 07.MOO.06.17.1).

Statistical Analysis
Projected sample size (n = 100) was based on the volume of clients coming into the clinic and the expected proportion of those who would consent to participate. Descriptive statistics, including frequency distributions, medians, means, and standard deviations, were calculated to describe baseline data as appropriate. Analyses of baseline characteristics, reasons for choosing yoga therapy, and other modalities used (in addition to yoga therapy) were performed using the data from all participants from the intake forms (see Appendix A). Primary analyses were conducted to view the (1) reasons for attending yoga therapy, and (2) modalities participants reported using in addition to yoga therapy.

Primary analyses consisted of counts and frequencies for baseline characteristics and other modalities chosen. Baseline characteristic variables were all categorical and therefore have been provided as frequency counts and percentages of the total sample. Participants were able to select multiple reasons for coming to yoga therapy, which were then collapsed into four primary categories: (1) pain, (2) mental health, (3) health conditions, and (4) general wellness concerns. Exploratory analysis was performed graphically to visualize the baseline PROMIS scores from only the respondents who completed the PROMIS-29 forms. All analyses and plots were completed in R, version 3.5.2.

Results
Over the course of the study period, 118 participants attending the clinic for yoga therapy were assessed for eligibility. Of those 118 participants, 48 were excluded because they declined to participate. There was one account of duplicate data, which was removed from analysis. A total of 70 participants completed the intake; of that total sample, 65 also completed the PROMIS-29 forms.

Primary
Table 1 presents the baseline participant characteristics as counts and percentage of the total sample (n = 70), along

<table>
<thead>
<tr>
<th>Table 1. Pooled Demographics</th>
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<tbody>
<tr>
<td><strong>Baseline Characteristic</strong></td>
</tr>
<tr>
<td>All participants</td>
</tr>
<tr>
<td>Age (y)</td>
</tr>
<tr>
<td>20–39</td>
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<tr>
<td>40–59</td>
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<tr>
<td>≥ 60</td>
</tr>
<tr>
<td>Sex</td>
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<tr>
<td>Female</td>
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<tr>
<td>Male</td>
</tr>
<tr>
<td>Race*</td>
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<tr>
<td>White</td>
</tr>
<tr>
<td>Black or African American</td>
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<tr>
<td>American Indian or Alaska Native</td>
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<tr>
<td>Asian</td>
</tr>
<tr>
<td>Ethnicity</td>
</tr>
<tr>
<td>Hispanic or Latino(a)</td>
</tr>
<tr>
<td>Not Hispanic or Latino(a)</td>
</tr>
<tr>
<td>Yearly income (USD)</td>
</tr>
<tr>
<td>&lt; $40,000</td>
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<tr>
<td>≥ $40,000–$79,999</td>
</tr>
<tr>
<td>≥ $80,000</td>
</tr>
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<tr>
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<td>Non-workforce</td>
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<tr>
<td>Part-time</td>
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<td>Relationship status</td>
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<tr>
<td>Less than Bachelors</td>
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<tr>
<td>Bachelors</td>
</tr>
<tr>
<td>Masters</td>
</tr>
<tr>
<td>Doctorate</td>
</tr>
<tr>
<td>Religious affiliation*</td>
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<tr>
<td>Catholic/Christian</td>
</tr>
<tr>
<td>Other world religion</td>
</tr>
<tr>
<td>Irreligious</td>
</tr>
</tbody>
</table>

*Respondents could select more than one option.
with the percentage of participants who did not respond to each of the baseline characteristic questions. A majority of the sample was both female (73.9%) and 40–59 years of age (53.6%). Most of the participants described themselves as White (82.9%) and Not Hispanic or Latinx (81.4%). Most of those who elected to participate in this study were employed full-time (54.3%), making $80,000 (USD) per year or more (52.9%), and held a graduate-level degree (60.0%).

Figure 1 shows a Venn diagram of client-reported reasons for attending yoga therapy at the first visit. The majority of participants cited pain (84.3%) as their reason for attending. Of those 59 participants who had selected pain, 23 of them (32.9% of the sample) selected pain as the only reason. Twenty-five (35.7%) participants selected mental health and/or general wellness reasons, and the fewest number of participants reported attending yoga therapy for a specific health condition (24.3%). Finally, the largest overlap was for those selecting both pain and mental health reasons for attending yoga therapy (14.3%).

Table 2 shows that most participants disclosed the use of other modalities in addition to yoga therapy (92.9%). The most popular was musculoskeletal manipulation (54.3%). Participants were least likely to report using additional rehabilitation therapies (11.4%).

**Figure 1.** Count and Proportion of Those Who Reported Attending Yoga Therapy for Various Reasons, $n$ (%)\(^{1}\)

![](image.png)

1. All values were reported at first visit. Participants were allowed to select more than one option. Total number and percentage of respondents selecting each option are represented beneath each category.

**Table 2.** Modalities Used in Addition to Yoga Therapy

<table>
<thead>
<tr>
<th>Description</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All participants</td>
<td>70</td>
</tr>
<tr>
<td>Mind/body</td>
<td>12 (17.1)</td>
</tr>
<tr>
<td>Traditional &amp; complementary</td>
<td>30 (42.9)</td>
</tr>
<tr>
<td>Musculoskeletal manipulation</td>
<td>38 (54.3)</td>
</tr>
<tr>
<td>Rehabilitation therapies</td>
<td>8 (11.4)</td>
</tr>
<tr>
<td>Conventional care</td>
<td>12 (17.1)</td>
</tr>
<tr>
<td>Nutrition</td>
<td>29 (41.4)</td>
</tr>
<tr>
<td>No. of additional modalities used</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>5 (7.1)</td>
</tr>
<tr>
<td>1</td>
<td>26 (37.1)</td>
</tr>
<tr>
<td>2</td>
<td>19 (27.1)</td>
</tr>
<tr>
<td>3</td>
<td>15 (21.4)</td>
</tr>
<tr>
<td>4</td>
<td>5 (7.1)</td>
</tr>
</tbody>
</table>

Mind/body = psychotherapy, health coaching, reiki, yoga, and meditation; traditional & complementary = Western herbal medicine, naturopathy, acupuncture & Oriental medicine, and ayurveda; musculoskeletal manipulation = massage therapy, chiropractic, and osteopathic medicine/manipulation; rehabilitation therapies = recreational, occupational, or physical therapies; conventional care = nursing, conventional medicine, and conventional approaches (e.g., medication); nutrition = nutritional care or approaches.

normal ranges (50 ± 5 points) at baseline. For all scales, 25% or less of the sample fell into moderate or severe ranges for their respective assessments.

**Discussion**

This preliminary study is the first to describe characteristics of clients attending a university-based student yoga therapy clinic in the United States. As the field of yoga therapy expands and becomes increasingly professionalized, more training programs will likely be housed in university settings, with the opportunity to expand the model of a student yoga therapy clinic. Understanding the characteristics of clients who present to a student yoga therapy clinic can help in the understanding of the experience of student trainees in such settings and the level of preparation they may receive for yoga therapy practice in other settings such as hospitals, integrative health clinics, community settings, and private practice. Consideration of the client composition of a yoga therapy clinic in comparison to what is known about the composition of yoga practitioners in the United States may elucidate the ways in which yoga therapy serves different or overlapping audiences with yoga practice more broadly. Lastly, such an analysis may demonstrate opportunities for such clinics to inform and recruit clients from segments of the population that may be underrepresented.

In this study, we found that just over half of participants worked full-time, had higher than median household incomes, and had obtained some form of graduate degree.
In addition, participants tended to be married, younger than 60 years old, identifying as female, White/Caucasian, non-Christian, and non-Hispanic/Latinx. Participants were likely to attend a single visit rather than several, and they were likely to utilize multiple healthcare modalities.

It is worth noting some of the unique features of this student clinic that may have affected the characteristics and participation of the client sample. First, the Master of Science in Yoga Therapy program is held in an executive format, on campus for 3 consecutive days (Friday evening, Saturday, and Sunday), 5 times each trimester (15 weekends per year). The student yoga therapy clinic hours are held during the days/times when students are present on campus, which can challenge continuity of care. Although clients can work with a single yoga therapy student over an entire year, their visits are limited to those 15 weekends. As such, clients cannot schedule weekly, biweekly, or even monthly visits, which may be routine in private yoga therapy practice. Individuals who require more frequent care may opt to receive yoga therapy in a different setting. The lapse between visit opportunities may also affect clinical outcomes as well as attendance and attrition over time. A student yoga therapy clinic with more regular hours may see a different composition of clients and different visit frequency.

Additionally, because students are required to complete a set number of clinic hours during their training, they may recruit one another’s friends, family members, or acquaintances to the clinic to ensure that their hours are met. Lastly, MUIH is an integrative health university that trains a diverse array of healthcare providers including acupuncturists, herbalists, nutritionists, and health coaches. Students from different programs may choose to swap visits with each other to meet their required hours. A professional yoga

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therapy clinic that does not include student providers with required hours to complete during a set period would likely use different recruitment strategies and therefore would have differences in composition and participation, even if it were located in a university setting.

Although these unique features may impact the composition of the clientele at this particular clinic, the demographic characteristics of this sample reflect national use of CIH in general and yoga in particular. Unfortunately, national surveys continue to suggest limited access of yoga and CIH by underserved and marginalized communities, and representation of such communities in yoga is historically poor. Although efforts have been made to address this issue in many sectors, yoga in the United States continues to generally be a practice of, by, and for educated White women, often those who are thin and young to middle-aged. Ironically, for many health conditions, symptoms and outcomes are worse for people of color, individuals with larger bodies, older persons, and those living in rural or urban areas. Yoga may not be reaching those who stand to benefit most from its practices.

Although many of the characteristics of this sample reflect broader national trends, the breakdown of religious identity was surprising. The largest category reported was irreligious, which may reflect trends toward less religiosity in the United States, especially among younger persons. In the present study only 34% reported identifying as Catholic or Christian, compared to 75% nationwide. Other world religions (Judaism, Islam, Buddhism, Hinduism, other) comprised almost 30% of participants in the present study, compared to less than 6% nationwide. This may reflect the proximity of this university to the major metropolitan cities of Washington, D.C., and Baltimore, which likely overrepresent religious minorities. Although there has been skepticism and concern about yoga in some Christian communities, in the authors’ experience this is not a commonly held view.

By far the most common reason for seeking yoga therapy was pain, representing approximately 84% of all participants. Seventeen percent of those seeking yoga therapy for pain also reported mental health concerns, including stress, depression, and/or anxiety. Given the relationship between pain and mental health, this finding is not surprising. It also reflects findings from a survey of practicing yoga therapists who reported that mental health and pain were the most commonly reported concerns among their clientele. Approximately 36% of participants claimed seeking general wellness as a motivation for yoga therapy, but almost always (88%) in conjunction with some other health concern. Pain and mental health also represent the five most common reasons Americans report using CIH practices overall. All of this evidence suggests that yoga therapy training should include substantial focus on the management of both pain and mental health concerns, as well as their overlap. It also suggests that additional work may be needed to explore and advocate for the role of yoga in the management of other health and wellness concerns. Participants were generally using yoga therapy in conjunction with other modalities, both conventional and CIH practices; the most commonly used additional modality was musculoskeletal manipulation, including massage, chiropractic, and osteopathic care, perhaps due to the high proportion reporting pain as a motivator for seeking care.

Baseline PROMIS scores fell largely into the normal range, which may reflect use of yoga therapy for management of subclinical symptoms, prevention of increased symptom severity, the novelty of yoga therapy as a modality, health-seeking by the “worried well,” and/or the recruitment strategies used by student clinicians (friends/family, student swaps).

Limitations
This study provides a novel contribution to the growing literature to define yoga therapy practice and use in the United States, but it suffers from several noteworthy limitations. The sample size is small, and the intended sample of 100 participants was not reached because the primary study objective was to assess feasibility (unreported data; manuscript in preparation), an objective that had been met. Feasibility concerns and the need to substantially revise study procedures resulted in early stoppage at n = 70.) Although the participant enrollment rate was high and likely an accurate representation of the clientele at this particular clinic, it did not result in a large enough sample to conduct meaningful inferential analysis. And while these client characteristics likely accurately represent university-based student clinics in the United States, they are not necessarily representative of professional yoga therapy clinics or student clinics in other settings (e.g., yoga studios or hospitals). In fact, as part of their program practice, these same students also see clients in both inpatient and outpatient hospital settings, which reflect very different demographics than those seen in the university-based clinic. Other studies should be conducted to assess the client characteristics in other types of yoga therapy clinics nationwide.

Given that demographic characteristics of this sample reflected the same bias as yoga use in the United States, efforts should be made to advocate for greater access to yoga and yoga therapy among diverse populations. This may be done through intentional recruitment, satellite clinics, changes in fee structure, and training of diverse professionals. Because yoga and yoga therapy are used largely to manage pain and mental health, these areas should be a focus of training and continuing education while also exploring barriers to uptake by those populations. The use of yoga therapy for other concerns also warrants further exploration.

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Yoga is one of the most highly utilized CIH practices and is particularly well-suited to meet the needs and priorities of individuals with health concerns through targeted and tailored practices. IAYT-accredited yoga therapy training programs require students to undergo clinical experience, which hopefully reflects the clientele they are likely to see as practicing professionals. Unfortunately, little is known about the characteristics of yoga therapy clients. This study found that participants largely reflected the characteristics of CIH users in general and yoga users more specifically, being mostly female, educated, White, and non-Hispanic. Primary reasons for seeking care, including pain and mental health, reflected prior reports by yoga therapists. Participants also reported using several healthcare modalities, which may be an important clinical consideration. Although small, this study contributes to a growing understanding of those seeking yoga therapy care and may inform calls to action in response to that understanding in education, advocacy, and further research.

**Conflict-of-Interest Statement**

This study was an unfunded collaboration between the Maryland University of Integrative Health and the National University for Natural Medicine. All authors claim no financial conflicts of interest. SM, MS, and IBD are practicing yoga therapists and therefore may indirectly benefit from any increased interest in the field of yoga therapy.

**Acknowledgments**

The authors would like to thank the faculty and students of the MUH yoga therapy program who so graciously opened up their clinical teaching and learning to this research process, the support staff who assisted in logistics throughout the process, and of course the study participants.

**References**


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Appendix A. Sample Study Intake Form

Confidential

Visit 1: General Intake and Demographics

Please complete the survey below related to your experience with Yoga Therapy at MUIH.

Thank you!

Please enter the date:

(Format: MM/DD/YY)

Select your current age category:
- 19 years or under
- 20-29 years
- 30-39 years
- 40-49 years
- 50-59 years
- 60-69 years
- 70 years or over

Please specify your sex:
- Male
- Female
- Inter
- Neither
- Other

If "Other" please specify:

Select your highest level of education:
- I high school diploma
- Associate’s degree
- Bachelor’s degree
- Master’s Degree
- Professional Doctorate (e.g., MD, JD, ND)
- Doctor of Philosophy (PhD)
- Other

If "Other" please specify your level of education:

Please specify your race (choose all that apply):
- White
- Black or African American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander

Please specify your ethnicity:
- Hispanic or Latino/a
- Not Hispanic or Latino/a
Appendix A. continued

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<table>
<thead>
<tr>
<th>Please specify your religious affiliation(s):</th>
<th>Protestant</th>
<th>Catholic</th>
<th>Jewish</th>
<th>Muslim</th>
<th>Buddhist</th>
<th>Hindu</th>
<th>Agnostic</th>
<th>Atheist</th>
<th>Other Christian</th>
<th>Other non-Christian</th>
<th>I don’t have a religious practice</th>
<th>I don’t know</th>
</tr>
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<tbody>
<tr>
<td>Please provide your current gross (before tax)</td>
<td>Less than $10,000 USD per year</td>
<td>$10,000-$19,999 USD per year</td>
<td>$20,000-$39,999 USD per year</td>
<td>$40,000-$59,999 USD per year</td>
<td>$60,000-$79,999 USD per year</td>
<td>over $80,000 USD per year</td>
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<tr>
<td>Please provide your employment status:</td>
<td>Full-time</td>
<td>Part-time</td>
<td>Unemployed</td>
<td>Retired</td>
<td>On leave from work (disability, FMLA, etc.)</td>
<td>Householder</td>
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<td>Divorced</td>
<td>Widowed</td>
<td>Other</td>
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<tr>
<td>If Other, please provide more details:</td>
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Appendix A. continued
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What are your primary reason(s) for pursuing yoga therapy:

- Anxiety
- Fatigue/Lack of Energy
- Menopause
- Arthritis
- Fibromyalgia
- Menstrual Problems
- Back or Neck Pain
- Gynecologic Problems
- Cancer
- Headaches/Migraines
- Nerve pain including Carpal Tunnel Syndrome
- Chronic Pain
- Hypertension
- Neurological disorder (including MS, Parkinson's Disease)
- Depression
- Insomnia/Trouble sleeping
- Stomach or Intestinal illness including IBS
- Diabetes
- Joint Pain or Stiffness
- Erectile Dysfunction
- Other

If “Other” please specify your reason for pursuing Yoga Therapy:

If health modalities do you use for your concern(s) above, in addition to yoga therapy:

- Psychotherapy
- Western Herbal Medicine
- Recreational Therapy
- Nutrition
- Massage Therapy
- Nursing
- Occupational Therapy or Physical Therapy
- Conventional medical care
- Chiropractic care
- Osteopathic Manual Medicine/Manipulation
- Naturopathy
- Acupuncture/Oriental Medicine
- Health coaching
- Other

If you use “Other” modalities in addition to Yoga Therapy, please specify:

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