Indian Journal of Traditional Knowledge
Vol 21(3), July 2022, pp 475-488

Integrative Therapy based on Yoga, Ayurveda and Modern Western Medicine for treatment of high-risk cases of COVID-19: A telemedicine-based case series

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Received 09 October 2021; revised 23 June 2022

Additional File 1: Progress tracking during treatment

Here we furnish details about the progress during the course of treatment for each patient. It may be noted that though some patients started their treatment with modern western medicine, the presented case series pertains to Ayurveda-and Yoga-based treatment. Thus, the days referred to in the detailed presentation of each case are the days after the beginning of Ayurveda-and-Yoga-based treatment; for instance, Day 0 refers to the day when the first consultation with an Ayurveda doctor was done. It may be noted that the ICMR guidelines for testing and treatment of COVID-19 kept evolving during the study. Thus, some non-uniformity may be expected due to factors beyond our control. For instance, initially ICMR had mandated a second RTPCR test before terminating the treatment and isolation period of a patient even after recovery from symptoms. Later, the norms changed and COVID patients who had recovered from symptoms no longer needed a second test; their quarantine was terminated after a specified period of time. However, some patients did go for a second RTPCR, the details of which have been furnished in the respective case details.

Detailed history, treatment plan and progress tracking for P01

The patient presented with the following symptoms at the time of first consultation: occasional obstruction in throat while speaking for long; extreme weakness (as reported, the patient used to get exhausted even on doing his daily chores); heaviness in the abdomen (gastric upset); frequent bloating feeling in the stomach; bad smell and taste, reduced appetite. Moreover, he sounded very low and lacking in energy.

History of the present illness was taken, which is as follows. The patient was asymptomatic three weeks prior to the first consultation. Later, he developed fever and symptoms of pneumonia, following which he went to the hospital and underwent the RT-PCR test. He reported to have had fever for about 10 days until June 22, 2020. The patient was detected positive on June 24, 2020. Subsequently, he was prescribed the following allopathic medication for 10 days - Nizonide 500 mg (Nitazoxanide 500 mg), Doxy 100 mg (Doxycycline 100 mg), PAN 40 mg (Pantoprazole 40 mg), Vitamin C, Matilda-ER (Methylcobalamin, Pyridoxine and Folic acid), LCZ 5 mg (Levocetirizine 5 mg). On July 1, 2020, at the time of the first consultation for the Integrative Therapy, the patient was home quarantined. He also reported to have had dry cough and body-ache earlier, both of which no longer persisted at the time of his first consultation.

The following allopathic medicines were being taken regularly by the patient for DM and Hypothyroidism: Glimepiride-2 mg, Galvas-50 mg, Vobit-0.3 mg, Torcilin-10, Thyroxin 75 mcg. Despite taking allopathic medicines, the patient's blood sugar levels were generally as follows: FBS >200 mg/dL, PPBS >250 mg/dL; PPBS was reported to be 230 mg/dL on June 30.

Based on the symptoms at the time of first consultation and the patient's medical history, he following prescription for the Integrative Therapy was given:

Ayurvedic medicines and procedures prescribed: *Giloy Ghanvati* (3 doses of 2 tablets each to be taken after meal with lukewarm water), *Ashwagandha vati* (2 doses of 2 tablets each to be taken after meal), *Pathyadi Kwath - pravahi* (15 mL mixed with an equal quantity of lukewarm water to be consumed twice a day 30 min after meal), and Diabecon (2 doses of 1 tablet each to be taken 30 min before meal). The Yoga protocol designed for the patient comprised *Sukshma vyayama* (upper and lower body parts), breathing exercises (4 exercises with 5 iterations in each), *asanas* (*parshva sukhasana*, *sukhasana* twist, *utthana mandukasana*, *ardha ushtrasana*, *meru vakrasana*, *ardha halasana* with one leg folded, *anantasana*, *pawan muktasana*); *Shavasana*, *Pranayama* (sectional breathing and full yogic breathing, *anulom-vilom*, *bhramari*, *udgeet*), and *Dhyana*. Looking at the anxiety level of the patient, he was also suggested to practise *Yoga nidra*[1](guided Yogic sleep and relaxation practice), for which he was provided a link to guided audio instructions for *Yoga nidra* (in Hindi language) by Swami Satyananda Saraswati[2], the duration of the practice being 42 min.

The patient complied to the prescribed medication and suggested procedures almost fully; he was also very regular with the yoga sessions. Moreover, he adopted many modifications and yoga in is lifestyle. During follow-up, he several times remarked that he could feel many changes in his overall health in such a short span of time.

Details of the patient's progress and compliance during the course of the treatment are given in Table 1. More details about this case may be found in the case report[3].

Detailed history, treatment plan and progress tracking for P02

The patient presented with the following symptoms at the time of first consultation: cough with sputum, mild chest pain, nasal and throat congestion and mild weakness.

History of the present illness was taken, which is as follows. The patient had developed fever some time back that persisted for 2-3 days, following which he underwent the RT-PCR test on July 4. The result of the test (shared with him on July 8) confirmed that he was COVID positive. Subsequently, he was prescribed the following allopathic medication - Vit D, Becasule, Bro-Zedex syrup, Novaclav 625. On July 9, 2020, at the time of the first consultation, the patient had been taking these medicines. Besides, the patient had been taking home-made *kadha*, drinking warm water and doing gargles.

The following allopathic medicines were being taken regularly by the patient for DM and Hypothyroidism: Gemer P1, Thyronorm 25 mcg. Despite taking allopathic medicines, the patient's blood sugar levels were observed as follows on April 22: FBS 118 mg/dl, PPBS 247 mg/dl; his TSH was found to be 5.6 on April 22. The patient also reported that his SpO2 level remained around 92-93.

Based on the symptoms at the time of first consultation and the patient's medical history, he following prescription for the Integrative Therapy was given:

Ayurvedic medicines and procedures prescribed: *Lavangadi vati* (2 doses of 2 tablets each to be sucked after meal), *Giloy Ghanvati* (3 doses of 2 tablets each to be taken after meal with lukewarm water), *Pathyadi Kwath - pravahi* (15 mL mixed with an equal quantity of lukewarm water to be consumed twice a day 30 min after meal), and Diabecon (2 doses of 1 tablet each to be taken 30 min before meal), *nasya* (putting 2 drops of oil in each nostril) to be done twice a day (morning and evening) with mustard oil; steam inhalation and gargles with medicated water containing *ajowan caraway*, rock salt and turmeric.

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts); Breathing exercises (4 exercises with 5 iterations in each); *Asanas*: (*tadasana*, *triyaktadasana*, *trikonasana*, *hastapadasana*, *ardhachakrasana*, *utthana mandukasana*, *vakrasana*, *bhujangasana*, *shalabhasana*, *ardhahalasana*, *matsyasana*); *Shavasana*; *Pranayama* (anulom-vilom, sectional breathing and full yogic breathing, *bhramari*, *udget*); *Dhyana.*

The patient was only partially compliant with respect to the ayurvedic medicines, but very regular and passionate about yoga sessions. He expressed his wish to continue the ongoing allopathic medication for DM, instead of taking Diabecon. Besides, he was reluctant to take *Lavangadi vati*; instead he started *Kantha Sudharak vati* on his own. However, he was regular in taking all other medicines and following the prescribed procedures; also, he continued to practise yoga with the recorded video provided to him for self-practice.

Details of the patient's progress and compliance during the course of the treatment are given in Table 2.

Detailed treatment plan and progress tracking for P03

The patient presented with the following symptoms at the time of first consultation: sore throat (mild), stomach ache (mild), weakness (mild), loose motions.

History of the present illness was taken, which is as follows. The patient also reported having tendency of watery stool (with normal frequency) since about two and a half months. The patient, after being tested positive for COVID on July 26, had the following vital measurements - BP: 187/127; PR: 94; SpO2: 98; Blood glucose FBS: 110-115, Random: 112. Due to high blood pressure, he was temporarily hospitalized. However, the BP came down to 150/93 within half an hour, following which he was given the option of being home quarantined, which the patient opted for. Thus, he was discharged within 2 h of admission and was prescribed the following allopathic medicines: Vitamin C, Zinc, Vitamin E (Evion 400 mg), Azithromycin.

The following allopathic medicines were being taken regularly by the patient: Galvas Met 50 mg/500 mg (for DMT2), Olmetrack 20 (for HTN). He informed that his blood glucose level usually remained under control with his ongoing medication, and therefore he did not require any extra medicines for the same (however, hisHbA1c report dated May 27, 2020 showed the value of 7.1%, which is above normal).As reported by the patient, the blood glucose level (fasting) remained controlled (between 110 and 115 mg/dL). As observed in the daily vitals shared by the patient (starting July 26 upto the time of first consultation on July 30), the blood pressure remained controlled (systolic mostly between 126 and 140 and diastolic mostly between 77 and 86.

Based on the symptoms at the time of first consultation and the patient's medical history, he following prescription for the Integrative Therapy was given:

Ayurvedic medicines and procedures prescribed: *Sanshamani vati* (3 doses of 2 tablets each to be taken after meal), *Ashwagandha vati*, *Pathyadi Kwath - pravahi* (15 mL mixed with an equal quantity of lukewarm water to be consumed twice a day empty stomach), *nasya* (putting 2 drops of oil in each nostril) to be done twice a day (morning and evening) with *anu taila*.

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts); Breathing exercises (4 exercises with 5 iterations in each); *Asanas*: (*tadasana*, *trikonasana*, *hastapadasana*, *ardhachakrasana*, *parshva sukhasana*, *sukhasana* twist, *utthana mandukasana*, *bhujangasana*, *shalabhasana*, *ardhahalasana* with one leg folded, *pawanmuktasana*); *Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *bhramari*, *anulom-vilom*, *udgeet*); *Dhyana*

The patient was almost fully compliant with respect to Ayurvedic medicines as well as yoga sessions. He regularly took medicines and attended most of the yoga sessions. By the end of the treatment, he was convinced about the therapy by the benefits he had observed. Therefore, he sought advice for other long-term medical issues not related to COVID. The same was duly addressed.

Details of the patient's progress and compliance during the course of the treatment are given in Table 3.

Detailed treatment plan and progress tracking for P04

The patient was asymptomatic at the time of first consultation.

History of the present illness was taken, which is as follows. She had no symptoms since the time of being tested positive for COVID on August 1 (sample shared on July 31). However, the patient had reported chronic constipation and (border-line) hypothyroidism. Considering the patient's age (75 years), and given the fact that she had been a patient of HTN since last 5 years, DM Type II since 15 years and had been on insulin (24U) since the last 4-5 years, she was considered to be in the highrisk group and given treatment as a preventive measure. The following allopthic supplements were prescribed: Vitamin C, Zinc, multivitamin.

The following allopathic medicines were being taken regularly by the patient: Janumet 50/500, Nebicard T, Glemi M2, Citanil, Ecosprin 75. The patient's FBS

(recorded 3-4 days prior to the first consultation) was reported to be 125 mg/dL and HbA1c (as on June 2020) was reported to be approximately 8%.

Based on the patient's medical history, the following prescription for the Integrative Therapy was given as a preventive measure:

Ayurvedic medicines prescribed: *Sanshamani vati* (1 BD), *Laghumalini vasant* (1 BD), Ayush *Kwath* (BD), Aloe vera + Amla juice.

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts); Breathing exercises (4 exercises with 5 iterations in each); *asanas*: (*Triyaktadasana*, *Trikonasana*, *Ardhachakrasana*, *Parshva Sukhasana*, *Utthana Mandukasana,Ardhaushtrasana*, *Bhujangasana*, *Shalabhasana*, *Ardhahalasana* with one leg folded, *Pawanmuktasana*); *Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari*, *Anulom-vilom*, *Udgeet*); *Dhyana*.

The patient was almost fully compliant during the first half of the course of treatment, and remained asymptomatic. However, during the second half, the patient started having constipation and gastric issues (which had been a chronic problem with her); subsequently, she was advised to discontinue the medicines but continue with the yoga sessions. This not only helped her overcome the gastric trouble, but also helped her with joint movement and muscular stiffness. At the end of the treatment, it was reported that she could now sit in cross-legged position - something she was not able to do prior to the treatment. She remained asymptomatic throughout the treatment. The patient's faith in Ayurveda and Yoga was evident in the fact that at the end of the treatment Ayurvedic consultation for DM was sought, which was duly provided after observing the most recent HbA1c report available and fasting + PP reports on following three successive days.

Details of the patient's progress and compliance during the course of the treatment are given in Table 4.

Detailed treatment plan and progress tracking for P05

The patient presented with the following symptoms at the time of the first consultation: sore throat, fever (mild) and weakness. He had developed the following symptoms: sore throat, mild fever and weakness on August 1. Following this, he underwent RAT on August 3 and was tested positive for COVID. Subsequently, he was prescribed the following allopathic medication - Doxy, Vitamin C (Citravite XT), Multivitamin (Vitneurin CZS), Cyra D, Zinc.

The following allopathic medicines were being regularly taken by the patient for Coronary artery disease (CAD), HTN, Tachycardia and acidity: tab. Dilzem-60, tab. Ecosprin 75, Zinetac.

Based on the symptoms at the time of the first consultation and the patient's medical history, the patient was prescribed the following Ayurvedic medication on August 3: *Sanshamani Vati* (1 BD), *Laghumalini Vasant* (1 BD). The symptoms persisted till August 9, and ceased after that (except that the patient continued to experience weakness). However, he joined the Integrative Therapy on August 10, when the only symptom prevailing was weakness. During the first consultation, the patient reported his SpO2 level to be consistently around 97-98. The patient continued to take the Ayurvedic medicines mentioned above.

The details of the Yoga protocol designed for the patient are given below.

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts); Breathing exercises (4 exercises with 5 iterations in each); *asanas*: (*Tadasana*, *Triyaktadasana,Trikonasana*, *Ardhachakrasana*, *Parshva Sukhasana*, *Sukhasana* twist, *Utthana Mandukasana*, *Bhujangasana*, *Shalabhasana*, *Ardhahalasana*, *Pawanmuktasana*);*Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari*, *Anulom-vilom*, *Udgeet*); *Dhyana*.

The patient was almost fully compliant with respect to Ayurvedic medicines as well as Yoga sessions. He regularly took medicines and attended all the yoga sessions. Moreover, he continued to practice yoga with the help of the recorded video provided to him. Within about 6 days of joining the Integrative Therapy, the patient reported complete relief and rejuvenation. He was extremely happy with the yoga sessions and shared his experiences with both the Ayurveda doctor and the Yoga therapist.

Detailed treatment plan and progress tracking for P06

The patient was tested positive for COVID on Aug 4 through RAT, and presented with the following symptoms at the time of the first consultation done on the same day: fever, cough with sputum, weakness. She also reported to be having gastric upset, chronic constipation and tendency of anxiety. Subsequently, she was advised the following allopathic medication: Citravite XT, Cap. Doxy, Vitneurin CZS, Cyra D, Zinc, Azee.

The following allopathic medicines were being taken regularly by the patient for HTN: Azilzu 40 (given half a dose and on alternate days).

Based on the symptoms at the time of the first consultation and the patient's medical history, the following Ayurvedic medicines were prescribed on Aug 4: Laghumalini vasant, Sanshamani vati, *kadha*. Later, as the illness progressed, *Talishadi churna* was added to the prescription.

The patient joined the Integrative Therapy on Aug 10. At the time of joining the IT, the patient reported to have fever (<100^{o}F), cough with sputum, weakness; the SpO2 level was reported to remain above 95. She continued with ayurvedic medicines specified above. The details of the yoga protocol suggested for the patient are given below:

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts); Breathing exercises (4 exercises with 5 iterations in each); *Asanas*: (*tadasana*, *triyaktadasana*, *trikonasana*, *ardhachakrasana*,*parshva sukhasana*, *sukhasana* twist, *utthana mandukasana*, *bhujangasana*, *shalabhasana*, *ardhahalasana*, *pawanmuktasana*); *Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *bhramari*, *anulom-vilom*, *udgeet*); *Dhyana*.

The patient was almost fully compliant to the prescribed treatment. She regularly took the medicines and attended all the yoga sessions. Moreover, she continued to practice yoga with the help of the recorded video provided to her after the completion of the treatment.

Details of the patient's progress and compliance during the course of the treatment are given in Table 5.

Detailed treatment plan and progress tracking for P07

The patient presented with the following symptoms at the time of the first consultation held on August 15: fever (since last 4-5 days), sore throat, cough with sputum, body-ache, weakness.

History of the present illness was taken, which is as follows. He had developed fever, body-ache and cough a few days back, following which he consulted an Allopathic doctor on August 11; subsequently, the following Allopathic medicines were prescribed for 5 days: Dolo 650, tab. Azee, tab. LCZ. When the symptoms persisted, the patient underwent RT-PCR on August 14, which confirmed that he was COVIDpositive.

The following medicines were being regularly taken by the patient: Nupenta LS cap. SR (SOS) - for acidity; Travatan eye drops, Refresh tears - for eyes.

Based on the symptoms presented and the patient's medical history, the following prescription for the Integrative Therapy was given:

Ayurvedic medicines and procedures prescribed: Oritus syrup, *Sanshamani vati*, *Laghumalini vasant*, Amynity Plus Syrup, Arogyavardhini vati, steam and gargles; some modifications were done to the prescription based on the patient's response and further condition, as reflected in the details furnished in Table 6. Besides the above medicines, the patient had been taking *kadha* twice a day on his own Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts without neck rotation); Breathing exercises (4 exercises with 5 iterations in each); *asanas*: (*Tadasana, Triyaktadasana, Virabhadrasana, Parshva Sukhasana, Utthana Mandukasana,* supported *Supta Vajrasana*, *Vakrasana*, *Pawanmuktasana*; *Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari*, *Anulom-vilom, Udgeet*); *Dhyana*.

The patient was largely compliant. He stopped taking the Ayurvedic medicines after experiencing upset stomach (such as loose stools). He was counselled 2 days later to resume the medication, when he started taking half the prescribed dosage. Another couple of days later he resumed the full dosage. Also, he missed some of the guided yoga sessions. By Sep. 1, the patient reported complete relief and rejuvenation.

Details of the patient's progress and compliance during the course of the treatment are given in Table 6. The patient underwent RTPCR on September 7, which was negative.

Detailed treatment plan and progress tracking for P08

The patient presented with the following symptoms at the time of the first consultation: fever, body ache. He was subsequently prescribed the following Ayurvedic medicines: *Sudarshan Ghanvati* (1 TDS), Immunity capsules (1 TDS), tab. Fifatrol (1 BD). The next day he complained of nausea and loss of taste (or bad taste as described by the patient), when he was prescribed Zoemit tab. He underwent RTPCR the same day on August 24, and was found COVID positive.

The following medicine was being regularly taken by the patient for HTN: AmcardAT.

Based on the patient's medical history and the symptoms presented, the following prescription for the Integrative Therapy was given:

Ayurvedic medicines and procedures prescribed: *Laghumalini Vasant* (1 BD), *Sanshamani Vati* (1 BD), Amynity (2 teaspoon BD), Chyavanprash, steam inhalation and gargles.

Yoga Protocol: Breathing exercises (2 exercises with 5 iterations in each); *Sukshma Vyayama* (upper and lower body parts); *asanas* with 2 rounds each: *Parshva Sukhasana, Utthana Mandukasana, Ardha Halasana, Pawanmuktasana, Shavasana,*

Pranayama (sectional breathing and full yogic breathing, *Bhramari, Anulom-vilom, Udgeet*); *Dhyana*.

The patient was almost fully compliant. He kept taking half the prescribed dosage of medicines by mistake for the first few days, until this came to notice and he was accordingly suggested. He attended all the guided Yoga sessions and continued practising himself with the help of the recorded video provided to him. In a follow-up call after the treatment was over, he reported immense improvement in digestion (bowel movement) and stiffness in joints and muscles - the patient attributed this to *Usha paan* and Yoga. He was subsequently connected to a Yoga organization so that he could further pursue his yoga practice and continue to reap the benefits he had started experiencing.

Details of the patient's progress and compliance during the course of the treatment are given in Table 7. The patient underwent RTPCR on September 9, which was negative.

Detailed treatment plan and progress tracking for P09

The patient presented with the following symptoms at the time of the first consultation: fever, mild cough and cold.

History of the present illness was taken, which is as follows. He had developed fever and cough on August 23, following which he consulted an Allopathic doctor and was prescribed the following medication - Azithromycin and PCM for 5 days. Subsequently he underwent RAT on Aug 26 and was tested positive.

The patient was regularly taking the following medicines for his comorbidities: Rosuvastatin 10 mg (for cholestrol); Meslazin 1BD (for Ulcerative Colitis); does a course of steroids (omnacotin) every year (starting 40 mg for 7 days, then 35 mg and so on upto 5 mg.; reported have used enema this year instead of steroids.

Based on the patient's medical history and the symptoms presented, the following prescription for the Integrative Therapy was given:

Ayurvedic medicines and procedures prescribed: Sudarshan Ghanvati (1 TDS for 5 days), Sanshamani vati (1 BD), Laghumalini vasant (1 BD), Chyavanprash (organic), Ayush Kwath, steam inhalation and gargles - all for 15 days; some addition was done to the prescription to address a new symptom later presented. The details have been furnished in Table 8.

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts); Breathing exercises (4 exercises with 5 iterations in each); *asanas*: *Tadasana, TriyakTadasana,*

Trikonasana, Ardhachakrasana, Parshva Sukhasana, Utthana Mandukasana, Ardha Ustrasana, Vakrasana, Bhujangasana, Shalabhasana, Ardhahalasana, Pawanmuktasana, Shavasana; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari, Anulom-vilom, Udgeet*); *Dhyana*.

The patient was almost fully compliant. He was regular in taking the medicines as well as attending the yoga sessions. Besides, the patient reported to be a spiritual seeker and a follower of a well-known tradition of yoga.

Details of the patient's progress and compliance during the course of the treatment are given in Table 8.

Detailed treatment plan and progress tracking for P10:

The patient presented with the following symptoms at the time of the first consultation: fever, sore throat, throat pain, cough with expectoration.

History of the present illness was taken, which is as follows. She had developed fever 2-3 days back, following which she underwent RT-PCR on August 26 and was tested positive. Subsequently, she was prescribed the following Allopathic medication: Azee 500 and Metrogyl 400 for 3 days, and Dolo (SOS).

The patient had been taking the following medicine regularly for HTN: Inzit 8 mg.

Based on the patient's medical history and the symptoms presented, the following prescription for the Integrative Therapy was given:

Ayurvedic medicines and procedures prescribed: Sudarshan Ghanvati (1 TDS) 5 days , Sanshamani vati (1 BD), Laghumalini vasant (1 BD), Chyavanprash (organic), Ayush Kwath, steam inhalation and gargles; some addition was done to the prescription to address a new symptom later presented. The details have been furnished in Table 9.

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts); Breathing exercises (4 exercises with 5 iterations in each); *asanas*: *Tadasana, Triyak Tadasana,*

Trikonasana, Ardhachakrasana, Parshva Sukhasana, Utthana Mandukasana, Ardha Ustrasana, Vakrasana, Bhujangasana, Shalabhasana, Ardhahalasana, Pawanmuktasana, Shavasana; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari, Anulom-vilom, Udgeet*); *Dhyana*.

The patient was almost fully compliant. She was regular in taking the medicines as well as attending the yoga sessions.

Details of the patient's progress and compliance during the course of the treatment are given in Table 9.

Detailed treatment plan and progress tracking for P11

The patient presented with the following symptoms at the time of the first consultation: diarrhea (loose stools with increased frequency).

History of the present illness was taken, which is as follows. He had developed fever a few days back, following which he underwent RT-PCR on August 26 and was tested positive. Subsequently, he was prescribed the following Allopathic medication: Immuxen (Vitamin C, Zinc – 1 OD), VSL #3 (probiotic – 1 BD). Besides, the patient also reported to be taking the following Ayurvedic medicines at the time of the first consultation: Coronil tab. (2 BD), *Swasari vati* (2 BD).

The patient had been taking the following medicine regularly for his comorbidities: Nebistar 2.5 mg (for HTN), ABSOLUT 3G (multivitamin). He also reported a history of sinusitis (since past 3 years).

Based on the patient's medical history and the symptoms presented, the following prescription for the Integrative Therapy was given:

Ayurvedic medicines and procedures prescribed: Kutaj Ghanvati (2 BD), steam inhalation, gargles, *usha paan*; some modifications were made to the prescription later when the patient did not show signs of relief. The details have been furnished in Table 10. The patient continued to take the Ayurvedic medicines he had already been taking.

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts); Breathing exercises (4 exercises with 5 iterations in each); *asanas*: *Tadasana, Triyak Tadasana, Trikonasana, Ardhachakrasana, Parshva Sukhasana, Utthana Mandukasana, Ardha Ustrasana, Vakrasana, Bhujangasana, Shalabhasana, Ardhahalasana, Pawanmuktasana, Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari, Anulom-vilom, Udgeet*); *Dhyana*.

The patient was quite compliant. He was regular in taking the medicines as well as attending the yoga sessions. However, he took Allopathic medication on his own at times. The patient felt immensely benefited with yoga practice and consequently joined regular yoga practice soon after completion of the above treatment plan.

Details of the patient's progress and compliance during the course of the treatment are given in Table 10. The patient underwent RTPCR on September 16, which was negative.

Detailed treatment plan and progress tracking for P12

The patient presented with the following symptoms at the time of the first consultation, which was done at an Ayurveda hospital: fever and body-ache. After developing symptoms on Sep 01, she underwent RAT on Sep 02, was found positive and got admitted to the Ayurveda hospital the same day. Subsequently, the patient was advised the following Ayurvedic medicines: *Nagaradi Kwath* 40 mL BD, *Amalaki churna* 3 gm BD,

Sanshamani gutika 2 BD, *Kantakari Avaleha* 2 tsp TDS for cough; some medicines were added to the prescription during the course of treatment for new symptoms presented by the patient. The details have been furnished in Table 11. Besides, the patient was advised to take PCM (SOS).

The patient had been taking the following medicine regularly for her comorbidities:

Ecosprin.

The patient joined the Integrative Therapy on Sep 4, when she presented the following symptoms: fever, body-ache and headache. While she continued to take the above Ayurvedic medicines, based on the patient's medical history and the symptoms presented, the following Yoga protocol was prescribed for her:

Yoga Protocol: Breathing exercises (4 exercises with 5 iterations in each); *Sukshma Vyayama* (upper and lower body parts); *asanas*: *Parshva Sukhasana*, *Sukhasana* twist, *Utthana Mandukasana*, *Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari*, *Anulom-vilom*, *Udgeet*); *Dhyana*.

The patient was almost fully compliant. She was regular in taking the medicines as well as attending the yoga sessions. In fact, she is a regular yoga practitioner.

Details of the patient's progress and compliance during the course of the treatment are given in Table 11.

Detailed treatment plan and progress tracking for P13

The patient presented with the following symptoms at the time of the first consultation: sore throat, body-ache, diarrhea and weakness. The patient also had mild cough with sputum.

History of the present illness was taken, which is as follows. The patient informed that he had a history of smoking until 2 years back, and had developed pulmonary tuberculosis a few months back; he also reported that mild cough with sputum had been recurring since then. After developing the initial symptoms, the patient, who had completed 6-months long treatment of pulmonary tuberculosis about one and a half months back, had visited the hospital on August 21, suspecting relapse of TB. Subsequently, he was prescribed the following medication for 5 days: Cap. Amoxycillin 500 mg (1 BD), Tab. Paracetamol 500 mg (SOS), Levocetrizine 5 mg (1 OD), Syp. Bromhexine (2 tsf BD). However, 2 days after the completion of the 5-day treatment, the patient developed fever again. As other symptoms started emerging, he got tested for COVID-19 on September 3, and was found positive. He had no fever at the time of the first consultation. He reported to have been taking Ayush Kwath on his own. He was also suggested the following Allopathic medication for fever: DOLO (SOS).

Based on the patient's medical history and the symptoms presented, the following prescription for the Integrative Therapy was given:

Ayurvedic medicines and procedures prescribed: Cap. Bowel Care (1TDS), Fifatrol (1TDS), Septalin (1 BD) – all for 3 days; Sanshamani vati (1 BD), Laghumalini vasant (1 BD), Ayush Kwath (3 gm BD), steam inhalation and gargles – for 15 days. Later, as specified in Table 12, he was additionally prescribed Vasavaleh, Syp. Jufex Forte during the course of the treatment.

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts); Breathing exercises (4 exercises with 5 iterations in each); *asanas*: *Tadasana*, *Triyak Tadasana*,

Trikonasana, *Ardhachakrasana*, *Parshva Sukhasana*, *Utthana Mandukasana*, *Ardha Ustrasana*, *Vakrasana*, *Bhujangasana*, *Shalabhasana*, *Ardhahalasana*, *Pawanmuktasana*, *Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari*, *Anulom-vilom*, *Udgeet*); *Dhyana*.

The patient was almost fully compliant. He was regular in taking the medicines and attended almost all the yoga sessions.

Details of the patient's progress and compliance during the course of the treatment are given in Table 12.

Detailed treatment plan and progress tracking for P14

The patient presented with the following symptoms at the time of the first consultation: sore throat, body-ache, and cough.

History of the present illness was taken, which is as follows. The patient reported that he had fever the

previous night and had taken DOLO 650 for the same. The patient was prescribed the following Ayurvedic medication for 2 days: Sudarshan Ghanvati (1 TDS), Sitopaladi Vati (1 TDS), Septilin tab. (1 BD), syp. Oritus (2 tsf TDS with lukewarm water). After taking the above medicines, the patient's symptoms no longer persisted. However, a few days later, when some of his family members started developing symptoms similar to COVID, the patient underwent RAT on September 7 and was tested positive. Subsequently, he was prescribed the following Allopathic supplements: Vitneurin CZS, Citravite XT.

The patient had been taking the following medicine regularly for his comorbidities:

Remipress H 2.5 (1 OD), Reconia Silver, Ecosprin 150. He also reported sleeping difficulty since last 4-5 years.

Though none of the symptoms presented by the patient persisted by the time he was tested positive, based on his medical history and age, the following prescription for the Integrative Therapy was given as a preventive measure:

Ayurvedic medicines and procedures prescribed: Sanshamani Vati (1 BD), Laghumalini Vasant (1 BD), Ayush Kwath (3gm BD), Chyawanprash, steam inhalation and gargles - all for 15 days.

Yoga Protocol: Breathing exercises (4 exercises with 5 iterations in each); *Sukshma*

Vyayama (upper and lower body parts); *asanas*: *Triyak Tadasana*, *Trikonasana*, *Hastapadasana*, *Ardhachakrasana*, *Parshva Sukhasana*, *Sukhasana* Twist, *Utthana Mandukasana*, *Bhujangasana*, *Shalabhasana*, *Ardhahalasana*, *Pawanmuktasana*, *Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari*, *Anulom-vilom*, *Udgeet*); *Dhyana*.

The patient was almost fully compliant. He was regular in taking the medicines and attended almost all the yoga sessions. In a follow-up call after the treatment, he reported relief in his chronic sleeping problem with yoga nidra; he said he was able to sleep for 4-5 h. continuously, which was a remarkable relief to his previous condition when he used to have uninterrupted sleep for hardly 2-3 h.

Details of the patient's progress and compliance during the course of the treatment are given in Table 13.

Detailed treatment plan and progress tracking for P15

The patient presented with the following symptoms at the time of the first consultation: fever and cough.

History of the present illness was taken, which is as follows. Her symptoms had started appearing on September 5 with body temperature fluctuating between101^{o}F to 102^{o}F; the fever persisted for 2 days and thereafter surfaced on and off. She underwent RTPCR on September 8 and tested positive. The patient's family informed that she was allergic to Sulpha drugs, Fluoroquinalones and Tinidazole. Subsequently, she was prescribed PCM 650 (SOS). She joined the Integrative Therapy 2 days after her first consultation, i.e. on September 11, when she presented with the following symptoms: fever, cough, mild diarrhea, reduced appetite and weakness.

The patient had been taking the following medicines regularly for her comorbidities: Insulin, Thyroxine 50. Besides, she reported sleeping difficulty and a disturbed sleeping pattern since last 5-6 years - tends to sleep around 2-3 a.m. and wakes up late at around 11 a.m. Also, occasional breathing problem was reported.

Based on the patient's medical history and the symptoms presented, the following prescription for the Integrative Therapy was given:

Ayurvedic medicines and procedures prescribed: Sudarshan Ghanvati (1 TDS),

Laxmivilas ras (1 TDS), Syp. Oritus (2 tsf TDS) - 6 days; Sanshamani vati (1 BD), Laghumalini Vasant (1 BD), Amynity (2 tsf BD), steam inhalation and gargles - 15 days. Some modifications were made to the prescription during the course of treatment based on the progress and new symptoms presented by the patient; details of the same have been furnished in Table 14.

Yoga Protocol: Breathing exercises (2 exercises with 5 iterations in each); *Sukshma*

Vyayama (upper and lower body parts without neck movements); *asanas*: *Parshva*

Sukhasana, *Utthana Mandukasana*, *Sukhasana* Twist, *Shavasana*; *Pranayama* (*Chandra* and *Surya Anulom Vilom*, *Bhramari*, *Udgeet*); *Dhyana*.

The patient was largely compliant. Some of the medicines that were prescribed TDS, were taken BD by her.

Though she attended most of the yoga sessions, she was observed to be reluctant at many instances. However, the patient claimed to have been significantly benefited by *Makarasana* and *Matsya Kridasana* at an instance (before being down with COVID) when her SpO2 levels had dropped to 87. She reported that within 30 minutes of practice of the two *asanas*, the SpO2 level touched 92 (these *asanas* had been suggested to her son when he was down with COVID).

Details of the patient's progress and compliance during the course of the treatment are given in Table 14.

Detailed treatment plan and progress tracking for P16

The patient presented with the following symptoms at the time of the first consultation: body ache (legs, back) and sore throat, weakness.

History of the present illness was taken, which is as follows. The patient had developed initial symptoms (fever, headache, body-ache and burning in eyes) on September 21; fever persisted for three days. He underwent RAT on September 22 and tested positive. Subsequently, he was prescribed the following Allopathic medication: Erythromycin; he was also given the following supplements: Vitamin C, Evion 400 (Vitamin E), PCM 500, Zinc Sulphate, Thiamine Pyridoxine. Besides, at the time of the first consultation, the patient informed that he had been taking home made *kadha* (thrice a day) made with *tulsi*, *adarak* (ginger), *dalchini* (Cinnamon), sonth (dried ginger powder) and *haldi* (turmeric); besides, he had been doing steam inhalation (occasionally) and had done *nasya* twice till the first consultation.

The patient had been taking the following medicine regularly for his comorbidity: Glimepiride 1 mg, Metformin 500 mg, Neurobion forte (1 OD). He also reported weakness in memory since past 3 years.

Based on the patient's medical history and the symptoms presented, the following prescription for the Integrative Therapy was given:

Ayurvedic medicines and procedures prescribed: *Sanshamani Vati* (2 TDS), *Ashwagandha Vati* (2 BD), *Laxmivilas Ras* (2 BD), *Basant Kusumakar Ras* 1 OD (replaced with *Madhumeh Kusumakar Ras* on patient's request), *Nasya* with *Anu taila*, steam inhalation, *usha paan* and gargles - all for 15 days.

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts); Breathing exercises (4 exercises with 5 iterations in each); *asanas*: *Tadasana*, *Triyak Tadasana*, *Trikonasana*, *Hastapadasana*, *Ardhachakrasana*, *Parshva Sukhasana*, *Utthana Mandukasana*, *Ardha Ustrasana*, *Vakrasana*, *Bhujangasana*, *Shalabhasana*, *Ardhahalasana*, *Pawanmuktasana*, *Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari*, *Anulom-vilom*, *Udgeet*); *Dhyana*.

The patient was almost fully compliant. He was regular in taking the medicines and attended all the yoga sessions (except that it took him a while to arrange the medicine *Madhumeh Kusumakar Ras*, which he started taking on October 2).

Details of the patient's progress and compliance during the course of the treatment are given in Table 15.

Detailed treatment plan and progress tracking for P17

The patient presented with the following symptoms at the time of the first consultation: anosmia, feeling cold and mild weakness; he also reported to have had loose stools 2-3 times that morning.

History of the present illness was taken, which is as follows. The patient had developed initial symptoms (fever, sore throat) around September 21-22. He took DOLO650mg, and the fever subsided in 2 days. Meanwhile, he underwent RTPCR on September 24 and tested positive. On September 26, the patient started experiencing anosmia, and reported to have had about 80% loss of smell. He was prescribed the following Allopathic prescription: Ivermectin 12mg (2 doses), Azithral 500 (5 days - dose over by the first consultation), Fabiflu: 1800 BD (5 days, 800 BD (4 days); he was also prescribed the following supplements: Zincovit BD, Rim cee (Vitamin C) and Maxirich (Multivitamin). He also had to take the following dose of insulin: 18 U morning, 12U evening due to uncontrolled blood glucose level.

The patient had been taking the following medicines regularly for his comorbidity: Istamet 50 mg/1000 mg (Matformin Hydrochloride), Amryl 2 mg; he had also been taking *neem+karela+jamun ras*. He also had to take insulin after being tested positive with COVID. He also used to take insulin (need-based) to control his blood

glucose level when required.

Based on the patient's medical history and the symptoms presented, the following prescription for the Integrative Therapy was given:

Ayurvedic medicines and procedures prescribed: *Giloy Ghanvati*, *Basant Kusumkar Ras*, *Amalki Churna+Haldi Churna+Vijaysar Churna*, *nasya* with *anu taila* - all for 15 days. He was also advised to do *Usha paan*, drink lukewarm water throughout the day and do steam inhalation.

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts); Breathing exercises (4 exercises with 5 iterations in each); *asanas*: *Tadasana*, *Triyak Tadasana*, *Trikonasana*, *Ardhachakrasana*, *Parshva Sukhasana*, *Utthana Mandukasana*, *Ardha Ustrasana*, *Vakrasana*, *Bhujangasana*, *Shalabhasana*, *Ardhahalasana*, *Pawanmuktasana*, *Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari*, *Anulom-vilom*, *Udgeet*); *Dhyana*.

The patient was almost fully compliant. He was regular in taking the medicines and attended all the yoga sessions. He expressed sincere desire to adopt Yoga in his lifestyle. He also consulted the doctor for long term management of diabetes.

Details of the patient's progress and compliance during the course of the treatment are given in Table 16.

Detailed treatment plan and progress tracking for P18

The patient presented with the following symptoms at the time of the first consultation: fever, cough with sputum (chest congestion), breathlessness. Also, his SpO2 level during the day was 92. He was recommended *Makarasana* and *Shithilasana*; after practising both, the patient reported SpO2 level to be 98 in the evening.

History of the present illness was taken, which is as follows. The patient started feeling unwell and feverish on September 24, following which he developed fever, and throat and chest congestion on September 26. Thereafter, he underwent RT-

PCR on September 28 and was tested positive. Subsequently, he was prescribed the following allopathic medicines: tab. Augmentin (1 BD for 5 days); tab. Deriphyllin 150 (1 TDS), Dolo 650 (1 TDS) – both for 3 days. He was also prescribed the following supplements: Vitneurin CZS (1 OD), tab. Citravite XT (1 OD) – both for 15 days. Besides, the patient also started doing self-nebulization owing to his seasonal bronchitis since childhood.

The patient had been taking the following medicines regularly for his comorbidities: Telmikind. Also, he has been keeping Asthma under control by self-nebulization at the onset of premonitory symptoms of congestion - has not had any bronchial spasm since last 15 years.

Based on the patient's medical history and the symptoms presented, the following prescription for the Integrative Therapy was given:

Ayurvedic medicines and procedures prescribed: cap. *Astha* 15 (3 days); syp. *Astha* 15, *Sanshamani Vati*, *Laghumalini Vasant*, *Chyawnprash*, *Ayush Kwath*, steam inhalation and gargles - all for 15 days.

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts - could not do

wrist rotation); Breathing exercises (3 exercises with 5 iterations in each); *asanas*: *Tadasana*, *TriyakTadasana*, *Trikonasana*, *Ardhachakrasana*, *Parshva Sukhasana*, *Utthana Mandukasana* (performed in *Sukhasana*), *ArdhaUstrasana*, *Vakrasana* (unable to do), *Shavasana*; *Pranayama* (*Bhramari*, *Anulom-vilom*, *Udgeet*); *Dhyana*.

The patient was almost fully compliant with regards to the medicines, but was not willing to take the yoga sessions. He regularly took all the medicines except *Kwath*; he discontinued yoga sessions after a few days (even the first few days were attended off and on in a reluctant way). In the few sessions that he attended the therapist observed that he found it difficult to follow the instructions. Therefore, the recorded video (supposed to be shared with him) was not shared with him.

Details of the patient's progress and compliance during the course of the treatment are given in Table 17.

Detailed treatment plan and progress tracking for P19

The patient was asymptomatic at the time of the first consultation.

History of the present illness was taken, which is as follows. The patient underwent

RTPCR on October 2 due to contact history with a positive case, and was himself found positive. Subsequently, he was prescribed the following Allopathic medicines: Azithromycin, Vitamin C, Zinc -all for 5 days. He also reported to be taking the following Homeopathic medicine: Immunomodulator (thrice per month for 3 months; already taken for 2 months). Besides, he was taking home made *kadha* prepared with *kali mirch* (black pepper), *laung* (cloves), *tej patta* (bay leaves), *ilaichi* (cardamom), *dalchini* (cinnamon), *haldi* (turmeric) + lemon.

The patient had been taking the following medicines regularly for his comorbidities: Telma-40 mg and a blood thinner. Besides other comorbidities, the patient also reported dyspnea on exertion as a persistent problem.

Based on the patient's medical history, the following prescription for the Integrative Therapy was given as a preventive measure:

Ayurvedic medicines and procedures prescribed: *Sanshamani Vati*, *Ashwagandha Vati*, *nasya* with *Anu taila*. He was also advised to do *usha paan*, steam inhalation, gargles and drink lukewarm water throughout the day.

Yoga Protocol: Breathing exercises (3 exercises with 5 iterations in each); *Sukshma*

Vyayama (upper and lower body parts); *asanas*: *Parshva Sukhasana*, *Sukhasana* Twist, *Utthana Mandukasana*, *Ardhahalasana* with folded leg, *Shavasana*; *Pranayama* (*Anulom-vilom, Udgeet*); *Dhyana*.

The patient was only partly compliant with respect to the medicines, but was very enthusiastic about the yoga sessions. Out of the medicines and procedures prescribed, he regularly took *Ashwagandha Vati* and did *nasya*. He was regular in attending yoga sessions, and very diligently continued self-practice after the guided sessions ended. During follow-up calls, he several times reported that his lungs were functioning much better and his breath holding capacity had improved with the practice of *pranayama*. He sounded very energetic and rejuvenated by the end of the treatment; he was particularly excited about *pranayama* and had started regularly practising it.

The patient remained asymptomatic throughout. He did not share his vitals regularly; instead, he informed the usual range of observations as follows: SpO2: 97-98; PR: 60-70; BP: 120/70. Also, he informed that the temperature remained normal. At the end of the isolation period, and the completion of the preventive treatment administered, the patient was prescribed the following for long term use based on his medical condition: *Sanshamani Vati* (2 BD after meal), *Kalmegh Vati* (1 BD after meal).

Detailed treatment plan and progress tracking for P20

The patient presented with the following symptoms at the time of the first consultation: fever, body-ache and weakness.

History of the present illness was taken, which is as follows. The patient had started feeling unwell on October 04, with temperature around 99^{o}F-100^{o}F, for which she took PCM. Thereafter, she remained afebrile for the next 3 days. However, the fever relapsed on October 8, following which she consulted the doctor on October 10 and was given the following Ayurvedic prescription for 2 days: *Sudarshan Ghanvati* (1 TDS), *Amlapittantak Yog* (1 TDS). She was also suggested to take PCM (SOS). She underwent the RTPCR on October 11 and was tested positive. Subsequently, she was prescribed the following Allopathic medicines: Azee 500 (1 OD for 3 days), PCM (SOS), Vitneurin CZS (1 OD for 15 days), Citranite XT (1 OD for 15 days).

The patient had been taking the following medicines regularly for her comorbidities: Amlodipine. She also reported emotional disturbance and disturbed sleep since March 2020 ever since loss of parent-in-law; tends to wake up every couple of hours.

Based on the patient's medical history and the symptoms presented, the following prescription for the Integrative Therapy was given:

Ayurvedic medicines and procedures prescribed: *Sudarshan Ghanvati* (1 TDS) and *Amlapittantak Yog* (1 TDS) for 3 days; *Sanshamani Vati* (1 BD), *Laghumalini Vasant* (1 BD), *Ayush Kwath* (BD), steam inhalation and gargles - all for 15 days.

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts); Breathing exercises (4 exercises with 5 iterations in each); *asanas*: *Tadasana*, *Triyak Tadasana*, *Trikonasana*, *Ardhachakrasana*, *Parshva Sukhasana*, *Utthana Mandukasana*, *ArdhaUstrasana*, *Vakrasana*, *Bhujangasana*, *Shalabhasana*, *Ardhahalasana*,

Pawanmuktasana, *Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari*, *Anulom-vilom*, *Udgeet*); *Dhyana*.

The patient was almost fully compliant. She was regular in taking all the medicines and attended most of the yoga sessions. Also, she mentioned several times during the course of the treatment that she was being immensely benefitedby *yoga nidra* with respect to her sleeping trouble.

Details of the patient's progress and compliance during the course of the treatment are given in Table 18.

Detailed treatment plan and progress tracking for P21

The patient presented with the following symptoms at the time of the first consultation: dry cough, and bad taste (which he attributed to the medicines). He also reported that he used to experience dry mouth and muscle cramps with increase in blood glucose level.

History of the present illness was taken, which is as follows. The patient had started developing the initial symptoms (sore throat/dryness in throat, body-ache) on October 14, following which he underwent RAT on October 15, and was tested positive. Subsequently, he was prescribed the following Allopathic medicines for 5 days: PCM 500, Doxy 400, LCZ, Vit C, Azithromycin 500, Syrup DPM. Also, the patient informed that he had been taking home-made *kadha* prepared with *dalchini* (cinnamon), *adrak* (ginger), *methi* and *curry patta* for the past one month. The patient had been taking the following medicines regularly for his comorbidities: Giolife 12G, Inventia (metformin). The patient also reported that nearly one and a half months back, his HbA1c was 10%, and that his FBS used to be around200mg/dl; however, after he started taking *kadha*, FBS had been around 140 mg/dl.

Based on the patient's medical history and the symptoms presented, the following prescription for the Integrative Therapy was given:

Ayurvedic medicines and procedures prescribed: *Pathyadi kadha*, *Sanshamani Vati*, Diabecon, *nasya* with *til* oil, *usha paan*, steam inhalation and gargles - all for 15 days; some modification was made to the prescription during the course of treatment based on the condition of the patient.

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts); Breathing exercises (4 exercises with 5 iterations in each); *asanas*: *Tadasana*, *Triyak Tadasana*, *Trikonasana*, *Hastapadasana*, *Ardhachakrasana*, *Parshva Sukhasana*, *Utthana Mandukasana*, *Ardha Ustrasana*, *Vakrasana*, *Bhujangasana*, *Shalabhasana*, *Ardhahalasana*, *Pawanmuktasana*, *Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari*, *Anulom-vilom*, *Udgeet*); *Dhyana*.

The patient was almost fully compliant. He was regular in taking all the medicines and attended all the yoga sessions.

Details of the patient's progress and compliance during the course of the treatment are given in Table 19.

Detailed treatment plan and progress tracking for P22

The patient presented with the following symptoms at the time of the first consultation: fever, body-ache, weakness, mild cough, reduced appetite (reported to be taking hardly any solid food since many days). Also, his SpO2 level was observed to be below 95.

History of the present illness was taken, which is as follows. The patient started feeling unwell and feverish on October 17 with temperature around 99^{o}F to 100^{o}F. Following this, he was prescribed Allopathic medication for 5 days, no records of which are available. When the symptoms persisted, the patient underwent RTPCR on October 21 and was tested positive. Thereafter, he was prescribed the following

Allopathic medicines: tab. Ivermectol 12 mg (1 OD for 3 days), tab. Zathrin 500 (1 OD for 7 days, though he took only for 5 days), Meftal Forte (SOS) - which was changed to DOLO 650 (SOS) on Oct 26; he was also given the following supplements: Limcee 500 (1 BD), Vitneurin CZS (1 OD).

The patient was reported not to have any comorbidities, though his blood glucose levels remained at borderline (as informed by the patient). However, high blood glucose levels were observed during COVID. The patient was advised to be cautious about eating habits. Also, he was suggested to get tested after recovery from

COVID so as to rule out the possibility of temporary onset of DM with COVID. After recovery, the patient underwent another blood test which revealed high blood glucose levels. The patient sought Ayurvedic treatment for the same; he was duly provided consultation.

Based on the patient's medical history and the symptoms presented, the following prescription for the Integrative Therapy was given:

Ayurvedic medicines and procedures prescribed: *Sanshamani Vati* (1 BD), *Laghumalini Vasant* (1 BD), Chyawanprash (1 tsf. daily with milk), Ayush Kwath (BD), steam inhalation and gargles - all for 15 days. Some more medicines, viz. *Sudarshan Ghanvati*, *Laxmivilas Ras*, *Ashwagandha Vati*, Himcocid, *Amlapittantak yog*, tab. *Sitopaladi* were progressively added to the prescription based on the condition of the patient; the details of the same have been furnished in Table 20.

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts); Breathing exercises (4 exercises with 5 iterations in each); *asanas*: *Tadasana, Triyak Tadasana, Trikonasana, Hastapadasana, Ardhachakrasana, Parshva Sukhasana, Utthana Mandukasana, Ardha Ustrasana, Vakrasana, Bhujangasana, Shalabhasana, Ardhahalasana, Pawanmuktasana, Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari, Anulom-vilom, Udgeet*); *Dhyana*.

The patient was almost fully compliant. He was regular in taking all the medicines and attended most of the yoga sessions.

Details of the patient's progress and compliance during the course of the treatment are given in Table 20.

Detailed treatment plan and progress tracking for P23

The patient presented with the following symptoms at the time of the first consultation: mild cough, body ache, weakness.

History of the present illness was taken, which is as follows. The patient started developing initial symptoms around October 21-22. She underwent RTPCR on October 23, and was tested positive, following which she was suggested to take PCM SOS. Subsequently, she joined the Integrative Therapy.

The patient was reported not to be taking any medicines regularly. The only chronic problem she had was seasonal bronchitis, which she had been managing with steam and herbal concoctions.

Based on the patient's medical history and the symptoms presented, the following prescription for the Integrative Therapy was given:

Ayurvedic medicines and procedures prescribed: *Sanshamani Vati* (1 BD), *Laghumalini Vasant* (1 BD), Ayush Kwath (BD), Chyawanprash (1 tsf. daily with milk), steam inhalation and gargles - all for 15 days. The following medicines were added to the prescription within two days: *Sudarshan Ghanvati* (1 TDS), *Astha*-15

(1 BD), Bresol (1 BD), syp. *Astha*-15 (2 tsf. TDS with lukewarm water) - to be taken for 3 days, and *Ashwagandha Vati* to be taken for 15 days; the details of the same have been furnished in Table 21.

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts); Breathing exercises (4 exercises with 5 iterations in each); *asanas*: *Tadasana, Triyak Tadasana, Trikonasana, Hastapadasana, Ardhachakrasana, Parshva Sukhasana, Utthana Mandukasana, Ardha Ustrasana, Vakrasana, Bhujangasana, Shalabhasana, Ardhahalasana, Pawanmuktasana, Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari, Anulom-vilom, Udgeet*); *Dhyana*.

The patient was almost fully compliant. She was regular in taking all the medicines and attended most of the yoga sessions.

Details of the patient's progress and compliance during the course of the treatment are given in Table 21.

Detailed treatment plan and progress tracking for P24

The patient presented with the following symptoms at the time of the first consultation: Sore throat (mild) with mild pain, weakness, loss of smell, taste.

History of the present illness was taken, which is as follows. The patient developed fever on October 17 (which persisted for about 6 days). Following this, she consulted a doctor on October 19, and was prescribed the

following Allopathic medicines: Doxycycline 100 (2 days), Calpol 650 (SOS), Syp. Piritone (2 days); Zincovit, Celin (Vit C) - this was never taken by the patient, Cap. Uprise (D3) (once a week for 2 weeks). She was also advised the following tests: RT-PCR, CBC, CRP, NS Agent (dengue). She underwent RTPCR on October 21 and was tested positive. Subsequently she was gven the following Allopathic prescription: Fabiflu 200mg, Calpol, Piritone, Zinconia, Celin - all for 10 days; she was also suggested some breathing exercises. Besides, the patient reported to be doing steam inhalation and gargles 3-4 times a day, and taking home-made *kadha* prepared with *dalchini* (cinnamon), *laung* (clove), *ilaichi* (cardamom), *adrak* (ginger), *giloy*, *tulsi* (basil), *kali mirch* (black pepper).

The patient had been taking the following medicines regularly for her comorbidity (ies): Olmizede 40.

Based on the patient's medical history and the symptoms presented, the following prescription for the Integrative Therapy was given:

Ayurvedic medicines and procedures prescribed: *Sanshamani Vati* (2 TDS), *Laxmivilas Ras* (2 BD), *Ashwagandha Vati* (2 BD), *Sarpgandha Vati* (1 OD at night after dinner), *kadha* (to be continued), *nasya* with *Anu taila*, *usha paan*, steam inhalation and gargles - all for 15 days. Some addition was done to the prescription during the course of treatment due to some new symptoms presented by the patient. Also, after recovery from other symptoms, the prescription was appropriately modified to help the patient get over post-recovery weakness. Details of the same have been furnished in Table 22.

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts); Breathing exercises (4 exercises with 5 iterations in each); *asanas*: *Tadasana*, *Triyak Tadasana*, *Trikonasana*, *Ardhachakrasana*, *Parshva Sukhasana*, *Utthana Mandukasana*, *Ardha Ustrasana*, *Vakrasana*, *Bhujangasana*, *Shalabhasana*, *Ardhahalasana*, *Pawanmuktasana*, *Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari*, *Anulom-vilom*, *Udgeet*); *Dhyana*.

The patient was almost fully compliant. She was regular in taking all the medicines and attended most of the yoga sessions.

Details of the patient's progress and compliance during the course of the treatment are given in Table 22.

Detailed treatment plan and progress tracking for P25

The patient presented with the following symptoms at the time of the first consultation: sore throat, cough, body-ache.

History of the present illness was taken, which is as follows. The patient felt body-ache, throat irritation and feverish around October 18 with temperature fluctuating around 99^{o}F-100^{o}F. Thereafter, she was prescribed the following Allopathic medicines: Azee 500 (1 OD for 5 days), tab. LCZ HS 1 OD, Dolo 650 SOS.

Based on the symptoms presented, the patient was prescribed following Ayurvedic medicines: Septilin (1 BD), Oritus (1 tsf. TDS with lukewarm water) - for 5 days.

The patient was not fully compliant; she started experiencing loss of taste on October 22 (which lasted 3 days) and remained febrile. Thereafter, she underwent RAT on October 24, and was tested positive. Subsequently, she was given the following Allopathic supplements: Vitneurin CSZ, Citravite XT; she was also suggested to take Dolo 650 (SOS) - for 15 days.

The patient had been taking the following medicines regularly for her comorbidity: Telmisartan 40 mg (1 OD).

The patient consulted again on October 26. Throat irritation and loss of taste had been resolved by then. The following symptoms were observed: fever (fluctuating between 99^{o}F-100^{o}F since the onset of symptoms), body-ache, loss of appetite, bad taste/no taste in food, weakness, mild stomach pain with urge to evacuate the bowel 3-4 times in a day (consistency of the stool normal). Based on her medical history and the symptoms presented, the following prescription for the Integrative Therapy was given:

Ayurvedic medicines and procedures prescribed: *Sanshamani Vati* (1 BD), *Laghumalini Vasant* (1 BD), *Ashwagandha Vati* (1 BD), Ayush Kwath (BD), steaminhalation and gargles - all for 15 days.

Yoga Protocol: Breathing exercises (4 exercises with 5 iterations in each); *SukshmaVyayama* (upper and lower body parts); *asanas*: *Triyak Tadasana*, *Trikonasana*, *Ardhachakrasana*, *Parshva Sukhasana*, *Sukhasana*

twist, *Utthana Mandukasana* (in *Sukhasana*), *Bhujangasana, Shalabhasana, Ardhahalasana, Pawanmuktasana, Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari, Anulom-vilom, Udgeet*); *Dhyana*.

The patient was almost fully compliant after October 26 (except that she did not take the kwath). She was regular in taking all the medicines and attended most of the yoga sessions.

Details of the patient's progress and compliance during the course of the treatment are given in Table 23.

Detailed treatment plan and progress tracking for P26

The patient presented with the following symptoms at the time of the first consultation on October 26: Gastric upset, burning sensation in stomach, and was prescribed *Amlapittantak Yog*, *Alsarex*, *Himcospaz*. The next day, on October 27, he consulted again for cough, when he was prescribed Koflet SF (in addition to the first prescription). The patient underwent RAT and RTPCR on October 28, both of which turned negative. The patient continued to experience new symptoms, and contacted the doctor again on October 30 for cough and sore throat, when he was prescribed *Sitopaladi* (1 TDS), *Septilin* (1 BD), *Laxmivilas Ras* (1 TDS), Koflet SF (2 tsp TDS with lukewarm water) - all for 5 days; he was also suggested to take PCM (SOS). The doctor also recommended blood test - reports received on Nov. 1 revealed low platelet count. Subsequently, the following medicine was added to his prescription: Orplat (1 BD for 3 days). Meanwhile, other family members of the patient started developing similar symptoms, which led the doctor to suspect COVID. The patient underwent another RTPCR on Nov. 2 at the doctor's suggestion, and was tested positive this time. At this time, the patient presented with the following symptoms: fever, cough with sputum, loose stools. After this, he was prescribed the following Allopathic medicines and supplements: Vitneurin CZS (1 OD), Citravite XT (1 OD) - given on Nov. 3 for 15 days; PCM 650 (1 TDS), Doxycycline 100 (1 OD for 5 days). Besides the patient reported to have been taking Ayush Kwath as a preventive measure.

The patient had been taking the following medicines regularly for his comorbidities: Amloz AT (1 OD), Glucoryl-M1 (1 OD), Thyroxine 50 mcg, Zyloric (1 OD). Based on the patient's medical history and the symptoms presented, the following prescription for the Integrative Therapy was given.

Ayurvedic medicines and procedures prescribed: *Sudarshan Ghanvati* (1 TDS), tab. *Sitopaladi* (1 TDS), syp. Koflet SF (2 tsf TDS with lukewarm water) - for 3 days; *Sanshamani Vati* (1 BD), *Laghumalini Vasant* (1 BD), *Ashwagandha Vati* (1 BD), Chyawanprash (Organic) (1 tsf OD), steam inhalation and gargles - for 15 days; the patient was also advised to continue taking *kwath*. Some modifications were made to the prescription during the course of treatment based on the condition of the patient.

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts); Breathing exercises (4 exercises with 5 iterations in each); *asanas*: *Tadasana, Triyak Tadasana*, *Trikonasana, Ardhachakrasana, Parshva Sukhasana, Utthana Mandukasana*, *Ardha Ustrasana*, *Vakrasana*, *Bhujangasana*, *Shalabhasana*, *Ardhahalasana*, *Pawanmuktasana, Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari, Anulom-vilom*, *Udgeet*); *Dhyana*.

The patient was almost fully compliant. He was regular in taking the medicines and attended all the yoga sessions.

Details of the patient's progress and compliance during the course of the treatment are given in Table 24.

Detailed treatment plan and progress tracking for P27

The patient presented with the following symptoms at the time of the first consultation on October 28: body-ache, and was prescribed the following Ayurvedic medicines: *Sudarshan Ghanvati* (1 TDS) and cap. Immunity (1 TDS) - for 5 days; she was also advised to take PCM 650 (SOS). Following this, she started experiencing more symptoms and underwent RAT on November 3, wherein she was tested positive. At this point, the symptoms presented by the patient were: fever, weakness and loss of appetite. Subsequently, she was prescribed the following Allopathic supplements: Vitneurin CZS (1 OD), Citravite XT (1 OD) for 15 days. Besides, the patient reported to have been taking Ayush Kwath.

The patient had been taking the following medicines regularly for her comorbidity: Telma AM (1 OD).

Based on the patient's medical history and the symptoms presented, the following prescription for the Integrative Therapy was given.

Ayurvedic medicines and procedures prescribed: *Sudarshan Ghanvati* (1 TDS),

Amalpittantak Yog (1 TDS), tab. Unexozim - for 3 days; *Sanshamani Vati* (1 BD),

Laghumalini Vasant (1 BD), *Ashwagandha Vati* (1 BD), Chyawanprash (Organic) (1 tsf OD), steam inhalation and gargles - for 15 days; the patient was also advised to continue taking *kwath*. Some modifications were made to the prescription during the course of treatment based on the condition of the patient.

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts); Breathing exercises (4 exercises with 5 iterations in each); *asanas*: *Tadasana, Triyak Tadasana, Trikonasana, Ardhachakrasana, Parshva Sukhasana, Utthana Mandukasana, Ardha Ustrasana, Vakrasana, Bhujangasana, Shalabhasana, Ardhahalasana, Pawanmuktasana, Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari, Anulom-vilom, Udgeet*); *Dhyana*.

The patient was almost fully compliant. She was regular in taking the medicines and attended all the yoga sessions.

Details of the patient's progress and compliance during the course of the treatment are given in Table 25.

Detailed treatment plan and progress tracking for P28

The patient presented with the following symptoms at the time of the first consultation on November 04: body-ache, mild cough and feverish feeling. He was prescribed the following Ayurvedic medicines: *Sudarshan Ghanvati* (1 TDS) and Coldab tablets (1 TDS), Septilin (1 BD) - for 2 days. The symptoms persisted and he underwent RAT on November 06, wherein he was tested positive. At this point, the symptoms presented by the patient were: mild cough with sputum, back-ache and loose motions. Subsequently, he was prescribed the following Allopathic supplements: Vitneurin CZS (1 OD), Citravite XT (1 OD) for 15 days; he was also prescribed DOLO 650 (SOS).

The patient had been taking the following medicines regularly for his comorbidity: Telma 40 (1 OD).

Based on the patient's medical history and the symptoms presented, the following prescription for the Integrative Therapy was given.

Ayurvedic medicines and procedures prescribed: Coldab tablets (1 TDS), Immunocare (1 BD), Septilin (1 BD), syp. *Kufrakshak* (2 tsf. TDS with lukewarm water)- for 3 days; *Sanshamani Vati* (1 BD), *Laghumalini Vasant* (1 BD), Ayush *Kwath* (BD), steam inhalation and gargles - for 15 days; *Ashwagandha Vati* (1 BD) was added on November 7. Some modifications were made to the prescription during the course of treatment based on the condition of the patient.

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts); Breathing exercises (4 exercises with 5 iterations in each); *asanas*: *Tadasana, Triyak Tadasana, Trikonasana, Ardhachakrasana, Parshva Sukhasana, Utthana Mandukasana, Ardha Ustrasana, Vakrasana, Bhujangasana, Shalabhasana, Ardhahalasana, Pawanmuktasana, Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari, Anulom-vilom, Udgeet*); *Dhyana*.

The patient was almost fully compliant. He was regular in taking the medicines and attended almost all the yoga sessions.

Details of the patient's progress and compliance during the course of the treatment are given in Table 26.

Detailed treatment plan and progress tracking for P29

The patient presented with the following symptoms at the time of the first consultation on November 07: body-ache, shivering, sore throat.

History of the present illness was taken, which is as follows. The patient started developing symptoms on November 5 with feverish feeling (though temperature was not recorded), body-ache and shivering. The next day she developed irritation in the throat. Following this, she underwent RAT on November 7, and was tested

positive. Subsequently, she was prescribed the following Allopathic supplements:

Vitneurin CZS (1 OD), Citravite XT (1 OD) for 15 days; she was also prescribed DOLO 650 (SOS).

The patient had been taking the following medicines regularly for her comorbidity: Amtas-AT (1 OD).

Based on the patient's medical history and the symptoms presented, the following prescription for the Integrative Therapy was given.

Ayurvedic medicines and procedures prescribed: *Sudarshan Ghanvati* (1 TDS), *Laxmivilas Ras* (1 TDS), Septilin (1 BD) - 3 days; *Sanshamani Vati* (1 BD), *Laghumalini Vasant* (1 BD), *Ashwagandha Vati* (1 BD), Ayush *Kwath* (BD), steam inhalation and gargles - for 15 days.

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts); Breathing exercises (4 exercises with 5 iterations in each); *asanas*: *Tadasana, Triyak Tadasana, Trikonasana, Ardhachakrasana, Parshva Sukhasana, Utthana Mandukasana, Ardha Ustrasana, Vakrasana, Bhujangasana, Shalabhasana, Ardhahalasana, Pawanmuktasana, Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari, Anulom-vilom, Udgeet*); *Dhyana*.

The patient was almost fully compliant. She was regular in taking the medicines and attended almost all the yoga sessions. In a follow-up call, she reported to be continuing with yoga practice with the help of the video recording provided to her.

Details of the patient's progress and compliance during the course of the treatment are given in Table 27.

Detailed treatment plan and progress tracking for P30

The patient presented with the following symptoms at the time of the first consultation on November 06: body-ache, fever. He reported to have had fever (100^{o}F) and chills since the previous evening. The following Ayurvedic medicines were prescribed to him: *Sudarshan Ghanvati* (1 TDS), cap. Immunity (1 TDS) - for 3 days; he was also suggested to take DOLO 650 (SOS). The next day, i.e. on November 07, he underwent RTPCR, and was tested positive. Subsequently, he was prescribed the following allopathic supplements: Vitneurin CZS (1 OD), Citravite XT (1 OD) for 15 days; DOLO 650 (SOS).

The patient had been taking the following medicines regularly for his comorbidity: Sartel H 40 (for past 1 year).

Based on the patient's medical history and the symptoms presented, the following prescription for the Integrative Therapy was given.

Ayurvedic medicines and procedures prescribed: *Sudarshan Ghanvati* (1 TDS), Immunocare (1 TDS) - 2 days; *Sanshamani Vati* (1 BD), *Laghumalini Vasant* (1 BD), Chyawanprash (1 tsf. daily with hot milk) steam inhalation and gargles - for 15days.

Yoga Protocol: *Sukshma Vyayama* (upper and lower body parts); Breathing exercises (4 exercises with 5 iterations in each); *asanas*: *Tadasana, Triyak Tadasana, Trikonasana, Ardhachakrasana, Parshva Sukhasana, Utthana Mandukasana, Ardha Ustrasana, Vakrasana, Bhujangasana, Shalabhasana, Ardhahalasana, Pawanmuktasana, Shavasana*; *Pranayama* (sectional breathing and full yogic breathing, *Bhramari, Anulom-vilom, Udgeet*); *Dhyana*.

The patient was almost fully compliant. He was regular in taking the medicines and attended almost all the yoga sessions. By the end of the treatment, he was strongly convinced about the positive impact yoga could have on his life, and was determined to adopt it in his lifestyle.

Details of the patient's progress and compliance during the course of the treatment are given in Table 28.

References

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Table 1 — Progress of patient P01 and evolution of the treatment plan

Day	Date	Vital measures	General remarks
0	Jul-01		Symptoms reported/ observed: occasional obstruction in throat while speaking for long; extreme weakness (gets exhausted even on doing his own daily chores); sounded very low and lacking in energy; heaviness in the abdomen (gastric upset); frequent bloating feeling in the stomach; bad smell and taste (occurred less frequently than it did earlier), reduced appetite; patient also exhibited disease-induced anxiety.
1	Jul-02		Most symptoms from the previous day persist; patient reported uneasiness in body.
2	Jul-03	FBS: 169	Improvement observed; approximately 25% relief reported in all the symptoms; lightness in the body reported.
3	Jul-04	FBS: 190, PPBS: 206	Doing Yoga twice daily; feeling good, with improvement in all the symptoms.
4	Jul-05	FBS: 160, PPBS: 206	Approximately 50% relief reported in all the symptoms; lightness in the body reported.
5	Jul-06	FBS: 155, PPBS: 175	No weakness; normal appetite; taste and smell almost normal; approximately 75% relief reported.
6	Jul-07	FBS: 140, Random: 110	No sore throat; no weakness; normal taste and smell; almost no other problem except mild heaviness in abdomen; approximately 80% relief reported.
7	Jul-08	FBS: 140, Random: 110	No problem except mild heaviness in abdomen.
8	Jul-09	FBS: 130, PPBS: 230	Second RT-PCR report received on July 8 was +ve, patient had anxiety again; slight change done in the prescription: i) Diabecon - 1 tab. in the morning and 2 tab. in the evening (earlier it was 1 tab. in the evening) ii) advised to take (*ajwain* + *saunf* + *dhaniya*) powder - 1/2 spoon, with lukewarm water, after meal.
9	Jul-10	FBS: 110, PPBS: 150	Improvement in all the problems (including heaviness in abdomen).
10	Jul-11	FBS: 110, PPBS: 150	No problem except mild heaviness in abdomen, improvement in anxiety; dose of Diabecon changed to 2 tab. BD (patient advised to start the revised dose from July 12).
11	Jul-12	FBS: 130, PPBS: 140	No problem except mild heaviness in abdomen; started Diabecon 2 tab. BD.
12	Jul-13	FBS: 99, PPBS: 112	No problem except mild heaviness in abdomen.
13	Jul-14	FBS: 108, PPBS: 112	Sample given for RT-PCR test; no problem except mild heaviness in abdomen.
14	Jul-15	FBS: 120, PPBS: 165	No problem except mild heaviness in abdomen.
15	Jul-16	FBS: 108, PPBS: 140	RT-PCR test inconclusive; no problem except mild heaviness in abdomen.
16	Jul-17	FBS: 90, PPBS: 140	No problem except mild heaviness in abdomen.
17	Jul-18		No problem except mild heaviness in abdomen; no more anxiety.
18	Jul-19		No problem except mild heaviness in abdomen.
19	Jul-20		Sample given for RT-PCR test; the patient's allopathic doctor reduced the dosage of his diabetes medication, i.e., Glimepiride changed from 2 mg to 1 mg; no problem except mild heaviness in abdomen.
20	Jul-21		Diabecon changed to Diabecon DS 1 tab. BD; no problem except mild heaviness in abdomen.
21	Jul-22		**RT-PCR reported no infection (negative)**; no problem except mild heaviness in abdomen.

Table 2 — Progress of patient P02 and evolution of the treatment plan

Day	**Date**	**Vital measures**	**General remarks**
0	July 9	SpO2: 92-93	Symptoms observed/reported: cough with sputum, chest pain (mild), nasal and throat congestion, weakness (mild)
2	July 11		Patient remained non-compliant till this day.
3	July 12		Patient started the prescribed medication partially; vitals not shared
5	July 14		Patient reported about 20% improvement in all the symptoms; yoga sessions commenced
8	July 17	SpO2: 95-96 Temp: 96.6-97.5	Patient reported about 50% improvement in all the symptoms; feeling light; SpO2 reported to fluctuate between 92 and 96
9	July 18	SpO2: 96-97 Temp: 97.1-97.6	
10	July 19		Patient reported about 90% improvement; only symptom persisting was cough with sputum; advised to do *kunjal* twice weekly.
11	July 20	SpO2: 96 Temp: 97.6	

Table 3 — Progress of patient P03 and evolution of the treatment plan

Day	Date	Vital measures		General remarks
0	July 30	SpO2: 97-98 BP sys: 125-144, BP dias: 70-90	PR: 76-88 Temp: 97.3-98.1	Symptoms reported/ observed: sore throat (mild), stomach ache (mild), weakness (mild), loose motions.
1	July 31	SpO2: 98 BP: 136/69	PR: 75 Temp: 97.2	
2	Aug 1	SpO2: 95-98 BP sys: 130-144 BP dias: 81-90	PR: 80-98 Temp: 97.5-97.8	Patient complained of weakness, dropping SpO2 and constipation (also said constipation was chronic) - Softvac advised for constipation; Makarsana and Shithilasana for SpO2.
3	Aug 2	SpO2: 97-98 BP sys: 141-160 BP dias: 86-96	PR: 80-85 Temp: 97.6-98.2	Patient reported stable condition.
4	Aug 3	SpO2: 97-98 BP sys: 138-151 BP dias: 90-93	PR: 80-87 Temp: 97.7-98.4	Patient reported continuing relief.
5	Aug 4	SpO2: 98-99 BP sys: 140-145 dias: 83-91	PR:78-95 Temp: 97.7-98.5 FBS: 125	Patient reported continuing relief.
6	Aug 5	SpO2: 97-99 BP sys: 138-154 BP dias: 84-95	PR: 79-90 Temp: 97.6-98.1	Patient's condition was found stable and he reported continuing relief.
7	Aug 6	SpO2: 98 BP sys: 141-148 BP dias: 89-91	PR: 80-90 Temp: 97.9-98.2	Patient's HbA1c report received (dated Aug. 5) with value 7.3.
8	Aug 7	SpO2: 97-98 BP sys: 133-141 BP dias: 81-87	PR: 83-95 PPBS: 159 FBS: 125 Temp: 98.0-98.4	Patient reported to be feeling better.
9	Aug 8	SpO2: 97-98 BP sys: 135-144 BP dias: 84-91 Temp: 98.2-98.8	PR: 85-90 PPBS: 182 FBS: 111	Patient progressively experiencing relief.
10	Aug 9	SpO2: 98-99 BP sys: 139-143 BP dias: 79-86	PR: 80-95 PPBS: 184 FBS: 100 Temp: 97.7-98.1	Same as the previous day.
11	Aug 10	SpO2: 97-98 BP sys: 125-139 BP dias: 77-87	PR: 77-88 PPBS: 131 FBS: 112 Temp: 97.7-97.8	Patient reported complete relief, including constipation.
12	Aug 11	SpO2: 98-99 BP sys: 123-125 BP dias: 75-55	PR: 85-95 Temp: 97.5-97.8 FBS: 90	
13	Aug 12	SpO2: 98 BP sys: 137-141 BP dias: 75-90	PR: 76-85 Temp: 97.4-97.9	
14	Aug 13	SpO2: 98 BP sys: 133-134 BP dias: 84	PR: 85-90 FBS: 83 PPBS: 135 Temp: 97.6-97.7	Patient reported to have been measuring blood glucose level regularly - range FBS approx. 110 mg/dL; PPBS approx. 150160 mg/dL).
15	Aug 14	SpO2: 99 BP: 138/85	PR: 85 Temp: 98.2	

Table 4 — Progress of patient P04 and evolution of the treatment plan

Day	Date	Vital measures		General remarks
0	Aug 1	SpO2: 93-95	PR: 73-77	Patient found to be asymptomatic
1	Aug 2	SpO2: 93-97	PR: 74-79	Patient remained asymptomatic
2	Aug 3	SpO2: 94-99	PR: 63-79	Vitals chart shared by the patient; SpO2 observed to be dropping below 95 on several occasions.
3	Aug 4	SpO2: 93-98 FBS: 299	PR: 67-80	Prone position asanas *makarasana* and *shithilasana* recommended for improving SpO2 level; no other symptom observed.
4	Aug 5	SpO2: 91-97	PR: 68-86	Patient continues to be asymptomatic.
5	Aug 6	SpO2: 94-96 FBS: 96	PR: 66-73	Patient continues to be asymptomatic.
6	Aug 7	SpO2: 95-98	PR: 66-76	Patient vomited twice - diagnosed to be due to acidity; SpO2 remained 95 or above this day onwards.
7	Aug 8	SpO2: 95-99 BP: 153/73	PR: 64-96	Patient continues to be asymptomatic.
8	Aug 9	SpO2: 96 BP: 153/79	PR: 68-72	Patient complained of headache and constipation (possibly due to gastric upset) and skipped the yoga session; discontinued *Sanshamani vati* and *Laghumalini vasant* hereon; SpO2 level remained 96 or above hereon.
9	Aug 10	SpO2: 97 BP: 156/78	PR: 70 FBS: 96	Patient discontinued medicines; did only yoga; increased intake of liquid diet - juice, coconut water, *tulsi* water etc. for constipation.
10	Aug 11	SpO2: 96-97	PR: 62-67	Only yoga done
11	Aug 12	SpO2: 96	PR: 63-64	
12	Aug 13	SpO2: 96-97 BP: 162/77	PR: 61-70 FBS: 194	Patient sought Ayurvedic intervention for diabetes - duly done.
13	Aug 14	SpO2: 97	PR: 62-67	
14	Aug 15	SpO2: 97 BP: 152/74 PR: 60	FBS: 75 PPBS: 311	
15	Aug 16	SpO2: 98 BP: 135/63 PR: 61	FBS: 131 PPBS: 234	
16	Aug 17	SpO2: 96 BP: 135/64 PR: 60	FBS: 110 PPBS: 267	
17	Aug 18	SpO2: 96 BP: 148/81 PR: 69	FBS: 105 PPBS: 209	The blood glucose levels observed from Aug 15 to Aug 18 were used for prescribing Ayurvedic medicines for DM (as requested by the patient)

Table 5 — Progress of patient P06 and evolution of the treatment plan

Day	Date	Vital measures	General remarks
0	Aug 4		Symptoms presented: fever, cough with sputum, weakness
6	Aug 10	SpO2: >95 Temp:<100.0	Patient complained of fever, weakness, cough with sputum (severe); besides, gastric upset and acidity were also reported
7	Aug 11	SpO2: 94-95 PR: 77-80 Temp: 99.0-99.5	
8	Aug 12	SpO2: 93-97 PR: 79-88 Temp: 98.0-99.4 BP sys:120-137, dias:72-84	Patient had fever and bouts of cough twice; complained of anxiety; *Makarsana* and *Shithilasana* suggested due to low SpO2
9	Aug 13	SpO2: 96-97 PR: 69-84 Temp: 98.0-98.4 BP sys:130-146, dias:77-86	Patient's condition reported to be much better than the previous day; no medicine taken for fever; cough better than previous day; *yoga nidra* recommended
10	Aug 14	SpO2: 96-97 PR: 70-81 temp: 98.3-98.4 BP sys:113-131, dias:70-76	Symptoms relieved to quite an extent; oxygen level improved; reported to have done *yoga nidra* and enjoying yoga; slept well
11	Aug 15	SpO2: 95-98 PR: 77-84 Temp: 98.0-98.5 BP sys:128-137, dias:62-83	Same as before
12	Aug 16	SpO2: 96-97PR: 77-81 Temp: 98.2-98.5 BP: 123/71	Mild cough; weakness - felt tired for a while after climbing stairs; no more anxiety; overall feeling much better, sleeping well
13	Aug 17	SpO2: 96-97 PR: 67-80 Temp: 98.2-98.5 BP: 134/81	started *Talishadi churna* and *Sanshamani vati* (SOS)
14	Aug 18	SpO2: 96-98 PR: 77-86 Temp: 98.2-98.4	symptoms same as above; took *Talisadi churna* only once due to discomfort caused by spicy
15	Aug 19	SpO2: 97-98 PR: 79-84 Temp: 98.4-98.5	Patient advised to take *Talisadi churna* twice with reduced quantity; sleeping well; eating properly
16	Aug 20	SpO2: 96-98 PR: 74-84 Temp: 98.0-98.4	Patient advised to do *nasya* with *til* oil; no fever medicine being taken for past few days; reported 50% relief in weakness; 80% relief in cough; relief in constipation without any additional medicines
17	Aug 21	SpO2: 96-98 PR: 74-87 Temp: 98.2-98.4	
18	Aug 22	SpO2: 96-98 PR: 71-81 temp: 98.3-98.5	
19	Aug 23	SpO2: 96-98 PR: 71-80 temp: 98.2-98.4	
23	Aug 27		*Nasya* not followed; still taking *talishadi churna* and multivitamin; no cough; mild weakness; overall good; recovered according to the patient. Still doing yoga regularly; yoga nidra at times

Table 6 — Progress of patient P07 and evolution of the treatment plan

Day	Date	Vital measures	General Remarks
0	Aug 15		Patient had developed fever, body-ache and cough on Aug. 11, was on allopathic medication. Present symptoms: fever, sore throat, cough with sputum.
1	Aug 16		Patient not approachable; vitals not shared
2	Aug 17		Sudarshan ghanvati added to prescription; symptoms prevailed; patient appeared to have *anxiety* over health issues; vitals not shared; not yet ready to do yoga
3	Aug 18	SpO2: 97, PR:86 Temp: 100	Symptoms prevailed; new symptom-loose stools; patient agreed to begin yoga sessions on Aug 19
4	Aug 19	SpO2: 98 PR: 80 Temp: 97	Patient complained of mouth ulcers and upset stomach (loose motions); Clotrin mouth paint, OroT, Vitneurin CZS (1 OD) suggested. Patient attributed stomach problem to the medicines and discontinued most medicines; increased intake of liquid (*lassi*, *chhachh*, lemon water); did not show up for yoga session
5	Aug 20	SpO2: 97 PR: 78 Temp: 97	Patient complained of cough, upset stomach, headache, bad taste, reduced appetite and extreme weakness; reported improvement in fever and having eaten solid food after many days; sleep cycle highly disturbed - *yoga nidra* was recommended for the same
6	Aug 21	SpO2: 95 PR: 69	Patient reported to have had severe headache in the morning - took medicine himself and slept again; reported feeling of restlessness in general and tiredness after yoga; all symptoms persist. Counselled and advised to resume medicines with half dosage, and have light meals with short gaps
7	Aug 22	SpO2: 97-99 PR: 75-82 BP: 118/84	Patient complained of headache and nausea in the morning, unable to eat, bad taste and upset stomach; syrup Himcocid (2 teaspoons thrice a day) added to the prescription, Zoemit and Diarex advised (only 1 tablet each); skipped yoga
8	Aug 23	SpO2: 95 PR: 79	Full dose of medicines resumed; reported 30% improvement in symptoms, appetite improving; skipped yoga
9	Aug 24		Vitals not shared
10	Aug 25	SpO2: 95-96 PR: 66-83	Patient reported improvement in symptoms with appetite getting normal- he sounded much better; stomach still a bit upset; little cough, weakness, bad taste persist. Advised to do yoga more regularly, practise *yoga nidra* and prone position *asanas*
11	Aug 26	SpO2: 97-98 PR: 72-82	Patient reported 50% improvement - particularly cough improved; weakness persisted
12	Aug 27		No cough, stomach improved, but loss of appetite persists and still feels weak; overall worse than the previous day; vitals not shared
13	Aug 28	SpO2: 97, PR: 94 BP: 115/78	Mild cough again, stomach still little upset, weakness better, appetite improved. Overall 70% improvement
14	Aug 29	SpO2: 97-98 PR: 94-100	Bitterness in mouth, throat persisted; stomach still a little upset; cough quite improved; appetite normal; liquid intake still increased
15	Aug 30	SpO2: 98 PR: 83	Patient feels like 80% recovered; still having loose motions (with normal frequency); mild bitterness in taste but eating properly, mild weakness, no cough
16	Aug 31	SpO2: 98-99 PR: 76-85 BPsys: 120-122 BP dias:78-83	
17	Sep 01	SpO2: 98 PR: 90	Medicines discontinued (dose completed); 100% recovery reported
25	Sep 09		**RTPCR negative** (sample given on Sep 07)

Table 7 — Progress of patient P08 and evolution of the treatment plan

Day	Date	Vital measures	General Remarks
0	Aug 23		Symptoms reported: fever, body-ache
1	Aug 24		Symptoms reported: body-ache, nausea, loss of taste (later reported by the patient as foul taste)
2	Aug 25		Symptoms reported: No fever, loss of taste (later, reported as bad taste), morning nausea (feeling of vomiting early in the morning)
3	Aug 26	PR: 66-72 Temp: 98.5-99.4 BP sys: 116-118, dias: 82-89	Patient complained of morning nausea; SpO2 not reported
4	Aug 27	PR: 72 Temp: 99.4 BP 126/88	Patient complained of morning nausea, mild heaviness in throat; about 75% relief reported; *yoga nidra* recommended
5	Aug 28	PR: 71-76 Temp: 98.6-99.3 BP sys: 118-125, dias: 80-86	Morning nausea and mild heaviness in throat persist; *usha paan* recommended
6	Aug 29	SpO2: 95-98 PR: 70-78 Temp: 98.5-99.6 BP sys: 125-129, dias: 77-86	Improvement in morning nausea; no more heaviness in throat; started *usha paan*; reported almost complete relief with normal diet, appetite
7	Aug 30	SpO2: 96-98 PR: 71-74 Temp: 97.9-98.9 BP sys: 122-129, dias: 84-87	Morning nausea not felt after gargles; 100% relief and rejuvenated
8	Aug 31	SpO2: 95-98 PR: 69-75 Temp: 97.9-99.2 BP sys: 117-133, dias: 83-87	Patient continues to be fine with no symptoms.
9	Sep 01	SpO2: 96-98 PR: 73-86 Temp: 98.2-100.6 BP sys: 122-129, dias: 80-86	Patient continues to feel fine with no symptoms.
10	Sep 02	SpO2: 96-98 PR: 77-85 Temp: 98.9-99 BP sys: 120-128, dias: 77-88	It was realised that the patient had been taking half the prescribed dosage of both *Sanshamani Vati* and *Laghumalini Vasant* (1 OD instead of 1 BD); advised to start taking the full dose.
12	Sep 04	SpO2: 96-98 PR: 77-79 Temp: 98.2-98.7 BP sys: 116-123, dias: 77-79	Patient started taking the full dose of medicines as suggested; continuing with steam inhalation, gargles and *usha paan*. No more feeling of morning nausea.
13	Sep 05	SpO2: 96-98 PR: 78-85 Temp: 98.4-99.3 BP sys: 115-127, dias: 74-86	Patient doing perfectly fine. Practising yoga twice a day since Sep 04 with the recorded video provided.
14	Sep 06	SpO2: 96-98 PR: 80-88 temp: 98.6-99.2 BP sys: 120-125, dias: 80	Patient doing perfectly fine. Practising yoga twice a day since Sep 04 with the recorded video provided.
16	Sep 08	SpO2: 96-98 PR: 77-81 temp: 97.5-98.8 BP sys: 119-125, dias: 73-83	Patient happily doing yoga twice every day. Reported remarkable improvement in digestion.
18	Sep 10		**RTPCR negative** (sample given on September 9).

Table 8 — Progress of patient P09 and evolution of the treatment plan

Day	Date	Vital measures	General remarks
0	Aug 26	Temp: 97.7	Symptoms reported: fever, mild cold, cough since past 3 days; no fever currently
1	Aug 27	SpO2: 97-98 Temp: 98.1-98.3	Patient did not develop fever, but felt feverish and weak; cough and cold persist
2	Aug 28	SpO2: 98 PR: 99-110 Temp: 98.-98.2	Feverish feeling and weakness persist, cough and cold better (70% improvement), appetite reduced; felt better after taking PCM
3	Aug 29	SpO2: 97-98 PR: 96 Temp: 98.1	Weakness and reduced appetite reported
4	Aug 30	SpO2: 97-98 PR: 99 Temp: 98.3-99.4	Mild fever recorded, mild cough, occasional nasal blockage (usual problem), extreme weakness, body-ache, appetite slightly reduced, bitterness in taste; also reported morning sickness; overall condition worse than the previous day; advised to do gargles and steam inhalation twice a day
5	Aug 31	SpO2: 99 PR: 90 Temp: 97.9	Occasional mild nasal and chest blockage; weakness, body-ache, reduced appetite, bad taste, morning sickness- symptoms persist
6	Sep 01	SpO2: 97-98 PR: 82-87 Temp: 97.4-98.3	All symptoms persist; overall condition same as before
7	Sep 02	SpO2: 98, PR: 83-92 Temp: 97.3-98.4	All symptoms persist but improved; 50%-60% improvement in overall condition
8	Sep 03	SpO2: 97-98 PR: 82-88 Temp: 97.3-97.9	Mild cough, mild bitter taste, mild pain in throat; weakness and reduced appetite persist; overall condition improved
9	Sep 04	SpO2: 98 PR: 82-86 Temp: 97.3-97.8	Condition same as before
10	Sep 05	SpO2: 98 PR: 92 Temp: 97.7	Mild cough, weakness, bad taste and morning sickness persist, appetite still not normal; throat pain improved by 60%-70%; reported constipation since 2-3 days; *Talishadi churna* and papaya suggested to the patient
11	Sep 06	SpO2: 98 PR: 82-92 Temp: 96.8-97.9	condition almost same as before
12	Sep 07	SpO2: 98 PR: 88-90 Temp: 97.1-98.0	Very mild cough and morning sickness, relief from constipation with papaya; other symptoms same as before; started taking *Talishdi churna* for cough; overall 70% recovery reported
13	Sep 08	SpO2: 99 PR: 102 Temp: 97.8	All symptoms relieved except very mild cough and weakness
14	Sep 09	SpO2: 98,PR: 98 Temp: 98.2	Same as before
16	Sep 11	SpO2: 99, PR: 102 Temp: 97.9	Same as before
17 to 21	Sep 12 to Sep 16		Follow-up done till Sep 16 - very mild cough and weakness persisted; patient felt fit enough to join back work on Sep 14; vitals remained normal; reported constipation once during this period; discontinued *Talishadi churna* and started taking *kali mirch+neem powder+haldi* powder+honey for dry cough; reported 90% recovery on Sep 16

Table 9 — Progress of patient P10 and evolution of the treatment plan

Day	Date	Vital measures	General remarks
0	Aug 27	SpO2: 99 Temp: 98.0-99.0	Initial symptoms: fever, sore throat, throat pain, cough with sputum' loose motions reported later during the day
1	Aug 28	SpO2: 99 PR: 87 Temp: 98.2-99.0	Symptoms reported: fever (mild), sore throat, throat pain, cough with sputum (feeling like cough is stuck), body-ache, weakness, loose motions, restlessness
2	Aug 29	SpO2: 98-99 PR: 87-91Temp: 98.4-99.0	Fever (mild), throat pain, cough and stomach improved; patient reported to be feeling very weak and restless; also developed headache
3	Aug 30	SpO2: 99 PR: 85 Temp: 97.7	Throat pain reduced, occasional nasal blockage (removed after steam inhalation), pain in legs, weakness; other symptoms relieved; overall 70%-80% relief; patient recalled that the previous day she had forgotten to take the regular BP medicine and attributed the headache to this - did not experience ever after; suggested to note BP daily, but could not arrange for the device
4	Aug 31	SpO2: 98 PR: 90 Temp: 98.7	Throat pain persists, mild pain in legs and mild weakness, occasional nasal/chest congestion relieved with steam inhalation; overall better than the previous day
5	Sep 1	SpO2: 95-99 PR: 72-87 Temp: 97.7-98.4	Mild throat pain; other symptoms same as before
6	Sep 2	SpO2: 99 PR: 77-89 Temp: 98.2-98.5	Throat pain much improved; mild pain in legs and weakness; nasal/chest congestion persists; overall 80% improvement reported
7	Sep 3	SpO2: 98-99 PR: 70-79 Temp: 97.9-98.6	Feeling much better than the previous day; mild throat pain and mild weakness persist
8	Sep 4	SpO2: 99, PR: 76-86 emp: 97.6-98.4	90% relief reported
9	Sep 5	SpO2: 96-97 PR: 78-83 Temp: 97.7-98.2	Throat pain worsened because of speaking for long in a meeting; also complained of running nose and sneezing; LCZ suggested by doctor (patient did not take), *Talishadi churna* suggested for throat
10	Sep 6	SpO2: 99, PR: 70-77 Temp: 97.7 – 98.1	
11	Sep 7	SpO2: 98, PR: 85 Temp: 98.2	Complete relief reported; no symptoms persist
12	Sep 8	SpO2: 98, PR: 96 Temp: 98.2	*Talishadi churna* started; patient continues to be in good condition
15	Sep 11	SpO2: 99, PR: 76 Temp: 97.8	

Table 10 — Progress of patient P11 and evolution of the treatment plan

Day	Date	Vital measures	General remarks
0	Sep 01	SpO2: 97, PR: 75 Temp: 96.8	Initial symptoms: diarrhea
1	Sep 02	SpO2: 98, PR: 72-87 Temp: 96.1-96.9	Frequency normal but stools still loose; no other symptoms reported.
2	Sep 03	SpO2: 97-98, PR: 71-74 BP: 135/80,Temp: 95.6-96.3	Same as the previous day.
3	Sep 04	SpO2: 97-98, PR: 66-77 BP: 138/82,Temp: 95.6-96.7	Diarrhea persists - frequency again increased; patient also reported mild stomach ache. However, he was observed to be consuming heavy and difficult-to-digest food items and was advised against it. Received discharge from govt. home isolation.
4	Sep 05	SpO2: 97-98, PR: 64-88 BP: 138/80,Temp: 95.1-97.7	Patient reported to have started course of an Allopathic medicine, Zenflox oz, since the previous night.
5	Sep 06	SpO2: 97-98, PR: 65-77 Temp: 97.3-97.5	
6	Sep 07	SpO2: 97-98, PR:70-75 Temp: 97.3-97.5	In the morning, patient reported relief with almost normal stools; he reported to be eating light food such as salted *daliya khichdi*, coconut water, fruits etc. However, later at night he reported trouble again with semi-formed stools thrice since evening. He was advised to start taking the prescribed Ayurvedic medicine thrice (instead of twice a day); however, the patient discontinued all medicines except the multivitamin and the one he had been taking regularly for HTN.
7	Sep 8	SpO2: 97, PR: 77-85 Temp: 97.3-98.3	Stomach still upset - had loose stools twice; also reported mild stomach ache. Again suggested to start taking the prescribed medicine thrice, have light meals, and control anxiety through regular practice of Yoga and Pranayama. Patient reported to be having papaya advised not to.
8	Sep 9	SpO2: 97, PR: 66-70 Temp: 97.5-97.8	Condition same as the previous day; started taking medicine prescribed under Integrative Therapy thrice (as suggested); all other medicines still discontinued.
9	Sep 10	SpO2: 98, PR: 78 Temp: 97.4	Condition same as before; RTPCR still positive; Yoga Nidra recommended
10	Sep 11	SpO2: 97, PR: 74 Temp: 97.5	*Giloy* started on doctor's recommendation; Zinc and Vitamin C also started
11	Sep 12	SpO2: 97-98, PR: 71-73 Temp: 96.7-97.4	Reported improvement in diarrhea (semi-formed stool only once); also reported better sleep after Yoga Nidra
12	Sep 13		Same as the previous day.
13	Sep 14		Condition worsened again - reported to have had motion thrice with mild pain in stomach.
15	Sep 16		**RTPCR negative** but stomach still upset; prescription revised by the doctor - *Kutajarishta* (3 tsp)+*Jirakadyarishta* (3 tsp) mixed with 6 tsp lukewarm water to be taken BD after meals.

Table 11 — Progress of patient P12 and evolution of the treatment plan

Day	Date	Vital measures	General remarks
0	Sep 02		Symptoms reported fever, body-ache
2	Sep 04		Symptoms reported: fever, body-ache, headache; vitals not shared
3	Sep 05		same as the previous day
4	Sep 06	SpO2: 97-99 , PR: 97-112 BP: 120/81,Temp: 99.3-99.8	all symptoms reported persist
5	Sep 07	SpO2: 97-98 , PR: 78-112 Temp: 98.6-100	Fever persists; no body-ache or headache; mild weakness reported. Medicine added to the prescription: *Swarna vasant malti ras* tab (125 mg 1 BD)
6	Sep 08	SpO2: 96-99, PR: 86-97 Temp: 98.4-99.7	Mild fever and weakness reported.
7	Sep 09	SpO2: 96-98, PR: 80-97 Temp: 97.7-98.6 RR (per min.): 19-24	No symptoms except mild weakness; started indulging in physical activities such as washing own clothes; respiration rate observed to be slightly high - practising Yoga Nidra and deep relaxation for it.
8	Sep 10	SpO2: 97-98, PR: 82-90 Temp: 97.9-98.8 RR (per min.): 20-26	No more weakness reported; new symptoms emerged - dry cough and breathlessness; HRCT chest done – features suggestive of viral pneumonic consolidation likely to be COVID-19, CT severity score: 2.
9	Sep 11	SpO2: 98-99, PR: 73-84 Temp: 98.0-98.6 RR (per min.): 20-23	Dry cough persists; SpO2 level normal despite breathlessness, so lung capacity observed to be preserved.
10	Sep 12	SpO2: 98-99, PR: 68-87 Temp: 95.9 RR (per min.): 21-25	Improvement in dry cough.
11	Sep 13	SpO2: 98-99, PR: 79-90 RR (per min.): 20-24	Improvement in dry cough as well as breathlessness, but talking for long causes trouble.
12	Sep 14	SpO2: 97-99, PR: 78-88 RR (per min.): 22-24	
13	Sep 15		Discharged from hospital.
14	Sep 16	SpO2: 97-99, PR: 80-90 Temp: 97.5-98.6	Talking for long still causes problem; no new symptoms; 90% recovery reported.

Table 12 — Progress of patient P13 and evolution of the treatment plan

Day	Date	Vital measures	General remarks
0	Sep 04	SpO2: 98, PR: 81-89	Symptoms reported: sore throat, diarrhea, body-ache, weakness; mild cough with sputum had been persistent for a while
1	Sep 05	SpO2: 96-98, PR: 90-98	Symptoms persist.
2	Sep 06	SpO2: 97-99, PR: 82-91	Relief from all symptoms except weakness and mild cough with sputum.
3	Sep 07	SpO2: 96-99, PR: 80-84	Same as the previous day.
4	Sep 08	SpO2: 96-100, PR: 75-87	Mild cough with sputum persists.
5	Sep 09	SpO2: 98-99, PR: 85-92	Patient reported 90% recovery, though cough persists.
6	Sep 10	SpO2: 98-99, PR: 80-100	Same as above.
7	Sep 11	SpO2: 98, PR: 90-100	Same as above.
8	Sep 12	SpO2: 96, PR: 90-95	Same as above.
9	Sep 13	SpO2: 99-100, PR: 85-96	Additional medicines prescribed: Vasavaleh (1 tsf BD), Syp. Jufex Forte (2 tsf TDS with lukewarm water).
10	Sep 14	SpO2: 99-100, PR: 85	Same as above.
11	Sep 15	SpO2: 98-100, PR: 80-83	Same as above.
12	Sep 16		The patient said that mild cough had anyways been resurfacing often owing to TB, and may have nothing to do with COVID. He claimed to be rejuvenated, have resumed normal appetite, and absence of any weakness or tiredness; 100% recovery reported. He also said he was determined to continue with Yoga.

Table 13 — Progress of patient P14 and evolution of the treatment plan

Day	Date	Vital measures	General remarks
0	Sep 01		Symptoms: fever (previous night), body-ache, sore throat, cough.
6	Sep 07		No symptoms at the time of enrolment; vitals not shared.
7	Sep 08	Temp: 99	No symptoms reported.
8	Sep 09	SpO2: 98,PR: 96	No symptoms reported.
9	Sep 10	SpO2: 98-99, PR: 93-95 Temp: 100	Reported fever; sleeping problem aggravated since last 2 days; also reported blood in stools. *Kwath* discontinued by the doctor, coconut water suggested; Yoga Nidra recommended for the sleeping trouble.
10	Sep 11	SpO2: 97-98, PR: 88-98 Temp: 93.9-96.1	No more fever or blood in stools; sleeping difficulty continues.
11	Sep 12	SpO2: 96-99, PR: 82-101 Temp: 94.7-95.9	Same as the previous day.
12	Sep 13	SpO2: 99, PR: 84-103 Temp: 96.0-96.5	Same as above.
13	Sep 14	SpO2: 96-99, PR: 80-98 Temp: 95.4	Same as above.
14	Sep 15	SpO2: 97-99, PR: 87-97 Temp: 95.2-95.4	Same as above.
15	Sep 16	SpO2: 96, PR: 100 Temp: 95	100% relief reported.
16	Sep 17	SpO2: 98, PR: 92	
17	Sep 18	SpO2: 97, PR: 100 Temp: 95.9	
18	Sep 19	SpO2: 98, PR: 82	

Table 14 — Progress of patient P15 and evolution of the treatment plan

Day	Date	Vital measures	General remarks
0	Sep 09		Symptoms: fever, cough.
2	Sep 11		Symptoms: fever, cough, diarrhea (mild), reduced appetite and weakness; excessive sweating and scanty urination also reported; vitals not shared; medicine *Laxmivilas Ras* replaced with Septilin (1 BD) and Sitopaladi (1 TDS).
3	Sep 12	SpO2: 95-96 PR: 82-91	Symptoms persist (except fever).
4	Sep 13	SpO2: 95 PR: 82	Overall about 50% relief reported by the patient; took coconut water to address the problem of scanty urination; advised to share blood glucose level.
5	Sep 14	FBS: 135	Called the doctor to complain about upset stomach and body-ache - Septilin replaced with Bacnil (1 TDS)
6	Sep 15	SpO2: 94-95 PR: 86-90 Temp: 98.0 FBS: 100	Developed body-ache and felt feverish; relief w.r.t. diarrhea (upset stomach) and reduced appetite; sweating still more than usual. Bacnil taken only once. Patient not sharing blood glucose level despite reminders.
7	Sep 16	RBS: 233	Weakness and mild cough persist, excessive sweating and scanty urination continue; stomach upset worsened again. Patient shared that she has been practising *Anulom Vilom* and *Kapaal Bhati pranayama* in the morning - this was discussed with the Yoga therapist and the patient was advised to discontinue *Kapaal Bhati*. Resumed Bacnil at night due to worsening of condition of stomach.
8	Sep 17	SpO2: 94,PR:82 FBS: 113 BP: 110/68	
9	Sep 18	SpO2: 93, PR: 97 Temp: 95.4	Relief in all symptoms except weakness and mild cough. Oritus replaced with Koflet syp. Patient discontinued Sanshamani Vati and Laghumalini Vasant after taking once.
10	Sep 19		Symptoms same as above. Patient took a new allopathic medicine (Canagliflozin 100 mg) for DM recommended by her physician; observed improvement in scanty urination problem.
11	Sep 20		Overall much better; weakness, mild cough and mild stomach problem persist.
14	Sep 23	Temp: 100	Developed fever - took PCM; improvement in all other symptoms.
15	Sep 24		Weakness still there; cough very-very mild (much improved); urination still not normal; all other symptoms eliminated; overall 90% recovery reported.

Table 15 — Progress of patient P16 and evolution of the treatment plan

Day	Date	Vital measures	General remarks
0	Sep 25	SpO2: 97, PR: 87-88 Temp: 96.4-97.5	Symptoms: body ache (mainly legs and back), sore throat, and weakness.
1	Sep 26	SpO2: 96-98, PR: 76-89 Temp: 96.3-96.8 FBS: 142 mg/dL	Symptoms: body-ache, sore throat, sputum, weakness.
2	Sep 27	PPBS: 184 mg/dL	Same as before; patient expressed concern about high blood glucose level.
3	Sep 28	SpO2: 98, PR: 81 Temp: 96.3 FBS: 148 mg/dL, PPBS: 213 mg/dL	Improvement in body-ache and sputum reported. Patient shared that the *kadha* consumed the previous day had *gud*, which could be the cause of sudden increase in blood glucose level; requested replacement for the prescribed medicine *Basant Kusumakar Ras*.
4	Sep 29	SpO2: 98, PR: 74-86 Temp: 96.5-96.8 FBS: 198 mg/dL, PPBS:162 mg/dL	
5	Sep 30	SpO2: 97-98, PR: 83-91 Temp: 96.2-97.6 FBS:146 mg/dL, PPBS: 152 mg/dL	Improvement in all symptoms: sore throat - mild and occasional; sputum improved (almost nil)
6	Oct 01	FBS: 145 mg/dL	Symptoms same as above; overall 80% - 85% relief reported.
7	Oct 02	SpO2: 98-99, PR: 78-86 Temp: 96.3-96.5	Overall 90% relief reported; started taking *Madhumeh Kusumakar Ras*
8	Oct 03	SpO2: 97-98, PR: 76-83 Temp: 96.7-97.1	100% recovery reported.

Table 16 — Progress of patient P17 and evolution of the treatment plan

Day	Date	Vital measures	General remarks
0	Sep 28	SpO2: 98-100, PR: 91-96 Temp: 98.0-98.5 FBS: 151 mg/dL, RBS: 200 mg/dL	Symptoms: anosmia, feeling cold, feverish feeling in the evening, mild weakness; also reported to have had loose stools 2-3 times in the morning.
1	Sep 29	SpO2: 99-100, PR: 92-93 Temp: 98.0-98.5 FBS: 151 mg/dL, PPBS: 143 mg/dL	Symptoms persist; about 10% improvement in anosmia.
2	Sep 30	SpO2: 98-100, PR: 92-104 Temp: 98.4 FBS:148 mg/dL, PPBS: 143 mg/dL	No more feverish feeling or feeling cold; 60% improvement in anosmia.
3	Oct 01	SpO2: 99-100, PR: 97-104 Temp: 98.0-98.4 FBS: 123 mg/dL; PPBS: 115 mg/dL	Same as before.
4	Oct 02	SpO2: 99-100, PR: 89-93 Temp: 97.8-98.0 FBS: 142 mg/dL, PPBS: 135 mg/dL	No more symptoms - 100% recovery reported.
5	Oct 03	SpO2: 100, PR: 93-101 Temp: 98.0-98.1 FBS: 125 mg/dL	Blood glucose level observed to be improving - halved insulin dose 2 days back, not taking insulin since the previous day
11	Oct 09		Follow-up call done - patient found in good health; continuing medicines and yoga practice.

Table 17 — Progress of patient P18 and evolution of the treatment plan

Day	Date	Vital Measures	General Remarks
0	Sep 29		Symptoms: fever, cough with sputum, chest congestion and breathlessness.
1	Sep 30	SpO2: 98, PR: 75-85 Temp: 98.4-100.3	Symptoms: fever, body-ache, weakness, sore throat, cough with sputum and reduced appetite.
2	Oct 01	SpO2: 98, PR: 62-88 Temp: 97.0-98.0 BP: 106/69	No fever or body-ache, improvement in weakness, cough and appetite; patient reported to be feeling overall better; however, he reported to have lost 3 Kgs in the past 15 days.
3	Oct 02	SpO2: 98-99, PR: 65-86 Temp: 96.9-98.1 BP sys: 115-125, dias:78	Patient reported to have felt tired after the yoga session; BP observed to be on lower side; advised to discontinue BP medicine for 2 days; patient advised to avoid cold things to eat; appetite getting normal.
4	Oct 03	SpO2: 98, PR: 73-78 Temp: 97.6-97.9 BP sys: 107-126, dias: 74-93	Continuing improvement in weakness, thick expectoration (steam inhalation advised), appetite normal; overall 60%, 70% recovery reported; slight drowsiness after yoga session reported.
5	Oct 04	SpO2: 98 PR: 74-76 Temp: 97.5-98.1 BP sys: 114-127, dias: 76-88	Symptoms same as before.
6	Oct 05	SpO2: 98 PR: 75-86 temp: 97.1-98.2 BP sys: 114-129, BP dias: 76-86	Continuing improvement in weakness; thick expectoration (taking steam with *ajwain* water); BP medicine still discontinued - patient feeling fine.
7	Oct 06	SpO2: 97-98 , PR: 76-86 Temp: 97.4-98.3 BP sys: 110-119, dias: 69-86	Patient in good health; continuing medicines.
10	Oct 09	SpO2: 97-98 , PR: 76-86 Temp: 97.4-98.3 BP sys: 110-119, dias: 69-86	patient in good health and reported to have almost recovered (except mild expectoration); continuing medicines; BP medicine still discontinued.

Table 18 — Progress of patient P20 and evolution of the treatment plan

Day	Date	Vital measures	General remarks
0	Oct 10		Symptoms: fever, body-ache, weakness.
2	Oct 12		Symptoms: body-ache, weakness, mild sore throat, heaviness in abdomen.
3	Oct 13	SpO2: 96-97, PR: 66-76 Temp: 98.5-98.6 BP sys: 118-128, dias: 71-82	Improvement in body-ache; other symptoms persist.
4	Oct 14	SpO2: 98-99, PR: 63-76 Temp: 98.5-98.8 BP sys: 118/78	Body-ache, sore throat persist; improvement in weakness; overall feeling better than the previous day.
5	Oct 15	SpO2: 97-98, PR: 79-86 Temp: 98.6-98.7 BP sys: 134/91	Body-ache and weakness persist; sore throat improved (very mild now); patient reported numbness in hands and a lot of pain in the feet the previous night. She said it was as if the pain is rotating and affecting different body parts. Also, reported to be getting tired after daily chores and feeling breathlessness after talking for long.
6	Oct 16	SpO2: 96, PR: 73-78 Temp: 97.9-98.6	Body-ache, sore throat and weakness persist; developed headache and constipation (new symptoms). Patient informed about extreme restlessness last night - had called the doctor at 1:00 a.m. due to severe headache and anxiety; patient took Disprin on her own. Doctor assessed this tobe gastric trouble due to improper dinner and suggested green tea. Patient also reported sleep lessness, and breathlessness after talking for long. *Yoga nidra* recommended for sleep; papaya recommended for stomach; Makarasana and Shithilasana suggested for breathlessness; steam inhalation also suggested
7	Oct 17	SpO2: 96-97, PR: 73-82 Temp: 98.8, BP: 110/71	Weakness, breathlessness and constipation persist despite eating papaya and doing steam inhalation; a lot of relief reported in sleeping trouble due to *yoga nidra*
8	Oct 18	SpO2: 98, PR: 75 Temp: 98.3, BP: 118/75	Weakness persists - felt weak in the morning, but improved by the evening. No more constipation. *Yoga nidra* done again - found very helpful.
9	Oct 19	SpO2: 97, PR: 90 Temp: 98.8, BP: 120/74	Weakness persists, but a lot of overall improvement reported.
10	Oct 20	SpO2: 96, PR: 65 Temp: 97.8, BP: 128/84	75%-80% recovery reported; however, weakness persists - patient reported pain in right hand after writing.
11	Oct 21	SpO2: 98, PR: 78 Temp: 98.2, BP: 123/70	
12	Oct 22	SpO2: 98, PR: 74 Temp: 98.6, BP: 125/77	Patient reported almost complete recovery, though still experiencing very mild weakness; felt fit enough to resume household work.

Table 19 — Progress of patient P21 and evolution of the treatment plan

Day	Date	Vital Measures	General Remarks
0	Oct 17	SpO2: 97-98, PR: 83-90 Temp: 95.5	Symptoms: dry cough, bad taste.
1	Oct 18	SpO2: 97, PR: 89, Temp: 96	Symptoms persist.
2	Oct 19	SpO2: 97, PR: 90 FBS: 190, PPBS:300	Symptoms same as before; blood glucose level observed to be high.
3	Oct 20	SpO2: 98 PR: 89 Temp: 95.4	
4	Oct 21	SpO2: 98, PR: 86, Temp: 94.5	
5	Oct 22	SpO2: 97, PR: 95 Temp: 94.5, RBS: 250	100% recovery reported.
6	Oct 23	SpO2: 97, PR: 88, Temp: 95.5 FBS: 200, PPBS: 280	Blood glucose level observed to be high.
7	Oct 24	SpO2: 97, PR: 98, Temp: 95.2 FBS: 203, PPBS: 280	The dosage of Diabecon doubled hereon to address the high levels of blood glucose.
8	Oct 25	SpO2: 97, PR: 91, Temp: 96.0 FBS: 168, PPBS: 348	
9	Oct 26	SpO2: 98, PR: 96, Temp: 95.4 FBS: 204, PPBS: 305	
10	Oct 27	FBS: 170, PPBS: 255	
13	Oct 30	FBS: 152, RBS: 258	Blood glucose level appears to be reducing.
14	Nov 01	FBS: 125, PPBS: 240	Blood glucose level appears to be reducing.

Table 20 — Progress of patient P22 and evolution of the treatment plan

Day	Date	Vital Measures	General Remarks
0	Oct 22	SpO2: 94-97 Temp: 99.0-100.0	Symptoms: fever, body-ache, weakness, mild cough, reduced appetite (hardly taking any solid food); SpO2 below 95 - *Makarasana* and *Shithilasana* recommended.
1	Oct 23	SpO2: 93-96 Temp: 98.3-102.0	Symptoms persist; still not eating anything solid.
2	Oct 24	SpO2: 92-96 Temp:98.3-101.0	Symptoms same as before; fever accompanied with cold feeling; SpO2 observed to be 92 in the morning, later rose to 94 and then 96.
3	Oct 25	SpO2: 95-96, PR: 77-85 Temp: 98.0-100.0	Fever persists with cold feeling; no more body-ache; appetite still very poor.
4	Oct 26	SpO2: 94-96, PR: 72-88 Temp: 98.0-100.0 FBS: 149, PPBS: 251	Condition same as before; tiredness and weakness worsened. Blood test done at the suggestion of doctor - blood glucose level found to be high. Following medicines added to the prescription: *Sudarshan Ghanvati* (1 TDS), *Laxmivilas Ras* (1 TDS) - for 3 days; *Ashwagandha Vati* (1 BD for 15 days)
5	Oct 27	SpO2: 95-97, PR: 77-88 Temp: 99.0-101.0	Vomited in the morning - felt light after that and ate solid food after many days. Fever, weakness, mild cough and reduced appetite persist.
6	Oct 28	SpO2: 94-95, PR: 77-86 Temp: 99.0-100.3	Heaviness in stomach - could hardly eat anything; taste of mouth changed found food very salty; coughing slightly increased - syp. Koflet SF given.
7	Oct 29	SpO2: 92-95, PR: 71-88 Temp: 98.5-102.0	Fever in the morning and at night, not during the day (99.5 at 10: 00 p.m.) no medicine taken for fever after morning; slight improvement in appetite. ; Himcocid (2 tsp. TDS), *Amlapittantak yog*, tab. *Sitopaladi* added to prescription.
8	Oct 30	SpO2: 95-96, PR: 71-81 Temp: 98.0-98.5	No fever; improvement in weakness; ate proper food; mild cough persists. Overall 70% recovery reported.
9	Oct 31	SpO2: 97-98, PR: 68-73 Temp: 97.0-97.3	
10	Nov 01		Complete recovery reported with normal appetite.
11	Nov 02	SpO2: 97-98 PR: 70-81 Temp: 97.0-99.0	
14	Nov 05		Patient found in good health during follow-up.

Table 21 — Progress of patient P23 and evolution of the treatment plan

Day	Date	Vital Measures	General Remarks
0	Oct 24	SpO2: 97 Temp: 98.5	Symptoms at the time of first consultation: mild cough, body ache, weakness; later she also reported to be having loose stools and chest congestion.
1	Oct 25	SpO2: 98 PR: 122 Temp: 100.4	Experiencing throat irritation since the previous night - Koflet syrup started; doing steam inhalation multiple times a day - slight improvement in congestion; patient developed fever - took PCM; loose stools and weakness persist; feeling cold.
2	Oct 26	SpO2: 97-98 PR: 88-115Temp: 97.8-100.1	Symptoms persist; experiencing new symptoms - irritation/burning sensation in feet, shivering due to weakness, appetite slightly reduced. Blood test done on doctor's suggestion - all parameters found okay. Patient took PCM due to fever.
3	Oct 27	SpO2: 96-99 PR: 103-116 Temp: 98.7-99.3	Symptoms persist; appetite coming back to normal; had motion twice. Patient took PCM due to mild fever.
4	Oct 28	SpO2: 99 PR: 96-100 Temp: 98.5-98.6	Improvement in chest congestion, stomach and appetite; no more throat irritation; still feels slightly cold.
5	Oct 29	SpO2: 99, PR: 97 Temp: 98.7	Stomach alright; appetite not normal yet; still feels cold and weak.
6	Oct 30	SpO2: 97-99 PR: 88-106 Temp: 98.2-98.6	No more congestion; only weakness and cold feeling persist; patient reported post-nasal drip. Overall 75% recovery reported.
7	Oct 31	SpO2: 96-98 PR: 97-98 Temp: 98.5-98.8	
8	Nov 01	SpO2: 95-96 PR:71-81 Temp: 98.0-98.5	Recovery reported; medicines continued.
12	Nov 05	SpO2: 97-98 PR:68-73 Temp: 97.0-97.3	Patient found to be in good health during follow-up.

Table 22 — Progress of patient P24 and evolution of the treatment plan

Day	Date	Vital Measures	General Remarks
0	Oct 24	SpO2: 97-99, Temp: 97.0-98.7 BP sys: 120-130, dias: 82-84	Symptoms at the time of first consultation: Sore throat (mild) with mild pain, weakness, loss of smell, taste.
1	Oct 25	SpO2: 99, PR: 82-85 Temp: 98.4 BP sys: 128-130, dias: 80-82	symptoms persist, but overall improvement patient reported to be feeling better than the previous day.
2	Oct 26	SpO2: 99, PR: 82 Temp: 98.4 BP sys: 130, dias: 80-84	Patient reported severe body-ache (new symptom) and weakness, and skipped the yoga session.
3	Oct 27	SpO2: 99, PR: 82-84 Temp: 98.4 BP sys: 125-130, dias:82-85	Improvement in body-ache; no moresorethroat; weakness persists.
4	Oct 28	SpO2: 99, PR: 82-84 Temp: 98.4 BP sys: 125-130, dias:82-84	Symptoms improving; weakness still there.
5	Oct 29	SpO2: 99, PR: 82 Temp: 100.0	Reported to be feeling feverish since the previous night; had fever during the day, but subsided by late evening - patient took PCM. She was suggested to take *Sudarshan Ghanvati* (2 BD) in case fever happens again; also suggested to take 6-7 glasses of lemon water per day, do meditation and deep breathing. The patient reported relief with respect to loss of smell and taste.
6	Oct 30	SpO2: 99, PR: 82 Temp: 97.6	Body-ache surfaced again with throat pain (new symptom); weakness persists. Patient started taking *Sudarshan Ghanvati.*
7	Oct 31		Body-ache and weakness persist; felt too drained out during the yoga session and started sweating - could not complete. Patient took *Sudarshan Ghanvati*.
8	Nov 01	SpO2: 99, PR: 82 Temp: 97.6-98.4	No symptom except weakness; improvement in weakness; overall much better.
9	Nov 02	SpO2: 99, PR: 82 Temp: 98.4	Patient reported to have almost recovered; medicines continued.
12	Nov 05		Patient found to be doing fine (except mild weakness) during follow-up. *Sanshamani Vati*, *Ashwagandha Vati*, *Sarpagandha Vati* and *nasya* continued; massage of calf muscles with coconut oil recommended; *Sudarshan Ghanvati* discontinued.

Table 23 — Progress of patient P25 and evolution of the treatment plan

Day	Date	Vital Measures	General Remarks
0	Oct 20		Symptoms: sore throat, cough, body-ache.
2	Oct 22		Symptoms: loss of taste.
3	Oct 23		Symptoms: loss of taste.
4	Oct 24		Symptoms: loss of taste. Underwent RAT tested positive.
6	Oct 26		Symptoms: fever, body-ache, weakness, loss of appetite, mild stomach pain with increased frequency of bowel evacuation and semi-formed stools.
7	Oct 27	SpO2: 93	All symptoms persist, except that the patient reported to be constipating - advised to take *trifla* or *isabgol* (that she was habitual of).
8	Oct 28	SpO2: 93-98, PR: 106 Temp: 100.0 BP: 158/80	Patient reported relief with respect to upset stomach; very bad taste in mouth, unable to eat properly; other symptoms (including fever) persist.
9	Oct 29	SpO2: >95 Temp: 99.0-99.8	All symptoms persist - fever, body-ache, weakness, bad taste, reduced appetite.
10	Oct 30	SpO2: 96, PR: 95-100 Temp: 98.4-99.8 BP sys: 130-162BP dias:75-85	Stomach upset again - semi-formed stools with increased frequency; trying a eat a little despite bad taste; extremely troubled by bad taste and body-ache. Patient reported not to be taking BP medicine since she got fever - advised by the doctor to resume.
11	Oct 31	SpO2: 95-98, PR: 102 Temp: 97.0-99.4 BP: 150/82	Resumed BP medicine. All symptoms persist; patient feeling very weak and tired; took DOLO for fever in the morning.
12	Nov 01	SpO2: 95 Temp: 99.0	Improvement seen in appetite; did not develop fever during the day despite not taking any medicine for fever - however had 99.0 temperature at night. Experiencing extreme weakness and pain in spine.
13	Nov 02	SpO2: 95 BP: 144/85	No fever; improvement with respect to bodyache and appetite; taste still bad; stomach still upset; weakness and fatigue persist.
14	Nov 03	SpO2: 95, Temp: 99.5 BP: 135/80	Developed fever again.
15	Nov 04	SpO2: 96	No fever, stomach fine; improvement in all symptoms - body-ache, weakness and taste; appetite still not normal. Overall 69% recovery reported.
16	Nov 05	SpO2: 96, BP: 133/87	No more fever.
17	Nov 06	SpO2: 98 BP: 135/79	Pain in spine; overall condition same as before; fatigue (though no fever) after doing household work - started sweating, feels cold at times.
18	Nov 07		Tiredness and weakness still there; taste and appetite not normal.
19	Nov 08	SpO2:98 BP:118/76	Pain in spine; taste getting better day by day; weakness persists, appetite not normal; sweating happens.
20	Nov 09	SpO2:98 BP: 133/88	
21	Nov 10	SpO2:97 BP: 138/87	Body-ache persists, weakness felt when too tired after doing household work; taste much better; appetite normal - felt hungry after many days. Overall more than 75% recovery reported.
28	Nov 17		Status found during follow-up: symptoms no longer persist; appetite and taste normal, no more weakness; almost complete recovery reported.

Table 24 — Progress of patient P26 and evolution of the treatment plan

Day	Date	Vital Measures	General Remarks
0	Oct 26		Symptoms: gastric upset.
1	Oct 27		Symptoms: gastric upset, cough.
4	Oct 30		Symptoms: cough, sore throat. Blood-test recommended.
6	Nov 01		Symptoms persist; low platelet count observed in blood-test report - Orplat (1 BD) added to the prescription.
7	Nov 02		Symptoms: fever, cough with sputum, upset stomach - loose stools.
8	Nov 03	SpO2: 94, PR: 67 Temp: 100.0	Symptoms: fever, cough with sputum, upset stomach - loose stools. SpO2 level below 95 *Makarasana* and *Shithilasana* recommended.
9	Nov 04	SpO2: 94-96, PR: 63-89 Temp: 98.7-100.0 BP: 119/75	Fever, cough with sputum and loose stools persist. SpO2 still below 95 - patient again advised to do *Makarasana* and *Shithilasana*
10	Nov 05	SpO2: 95-98, PR: 64-71 Temp: 98.6-100.5 BP: 112/79	Fever, weakness persist; appetite reduced (mostly on liquid diet); improvement with respect to cough with sputum; upset stomach semi-formed stools with increased frequency. Reported to have felt drowsiness during the day, vomited - took allopathic medicines Digene and Pantoprazole gadtro resistance (1 tab. each). *Septilin* continued for 5 days.
11	Nov 06	SpO2: 94-97, PR: 67-74 Temp: 98.6-100.0	Fever persists - develops at night, becomes normal during the day; fever is accompanied with weakness; mild dry cough and reduced appetite persist (mostly on liquid diet); improvement with respect to loose stools.
12	Nov 07	SpO2: 98, PR: 66 Temp: 98.5 BP: 118/82	No more fever; improvement with respect to weakness. Overall better than the previous day.
13	Nov 08	SpO2: 98, PR: 66-96 Temp: 96.0-97.6 BP sys: 115-120 BP dias: 76-80	Mild dry cough and slight weakness persist; no more loose stools; appetite normal. More than 80% recovery reported. *Sudarshan Ghanvati* given again for 2 days.
14	Nov 09	SpO2: 98-99, PR: 57-65 Temp: 97.5 BP sys: 116-119 BP dias: 79	
15	Nov 10	SpO2: 98, PR: 65 Temp: 97.2-97.5 BP sys: 115-117 BP dias: 79-81	
16	Nov 11	SpO2: 99, PR: 56-65 Temp: 97.5 BP sys: 110-119 BP dias: 82-86	
17	Nov 12	SpO2: 97-99, PR: 60-62 Temp: 97.8-98 BP sys: 101-112 BP dias: 78-80	No more symptoms. Complete recovery reported; occasional mild cough due to pollution.

Table 25 — Progress of patient P27 and evolution of the treatment plan

Day	Date	Vital Measures	General Remarks
0	Oct 28		Symptoms: body-ache.
6	Nov 03	SpO2: 94, PR: 97 Temp: 100.0	Symptoms: fever, weakness and loss of appetite. SpO2 level below 95 - *Makarasana* and *Shithilasana* recommended.
7	Nov 04	SpO2: 98-99, PR: 87-97 Temp: 98.7 BP: 164/97	Weakness and loss of appetite persist (mostly on liquid diet); no fever. SpO2 level improved.
8	Nov 05	SpO2: 96-97, PR: 88-106 Temp: 98.4-99.0 BP: 145/95	Symptoms persist; mild fever observed, though patient did not feel feverish; largely on liquid diet. *Sudarshan Ghanvati* and *Amalpittantak yog* continued for 2 days.
9	Nov 06	SpO2: 97-100 PR: 80-101 Temp: 98.6-99.2	Mild fever relapse; weakness persists; appetite getting normal.
10	Nov 07	SpO2: 98, PR: 84 Temp: 98.5 BP: 148/105	No more fever; improvement with respect to weakness.
11	Nov 08	SpO2: 95-97 PR: 88-90 Temp: 99.0-99.5 BP sys: 140-148 BP dias: 101-105	Mild fever, feels weak when in fever; appetite completely normal. Overall feeling much better. *Sudarshan Ghanvati* continued for 2 days; Fifatrol (1 BD) given for 2 days.
12	Nov 09	SpO2: 98-99, PR: 79-86 Temp: 98.5-98.6 BP sys: 130-136 BP dias: 89-93	
13	Nov 10	SpO2: 98-99, PR: 75-83 Temp: 97.5-98.5 BP sys: 137-140 dias: 94-95	
14	Nov 11	SpO2: 97-98, PR: 66-82 Temp: 98.4 BP sys: 110-134 BP dias: 82-93	
15	Nov 12	SpO2: 98, PR: 77-83 Temp: 97.2-98.4 BP sys: 133-134 BP dias: 96-101	Complete recovery reported.

Table 26 — Progress of patient P28 and evolution of the treatment plan

Day	Date	Vital Measures	General Remarks
0	Nov 04		Symptoms: body-ache, mild cough, feverish feeling.
2	Nov 06		Symptoms: mild cough with sputum, backache, loose stools.
3	Nov 07		Symptoms: cough, loose motions, weakness; no fever.
4	Nov 08	SpO2: 97-98, PR: 73-85 Temp: 97.9 BP: 145/94	Cough and weakness persist; no fever; relief from loose motions; reported to be eating properly and to have slept properly the previous night after many days.
5	Nov 09	SpO2: 97, PR: 74 Temp: 97.4 BP: 132/90	Cough and mild weakness persist. The following medicines added for 2 days: Coldab tablets, Immunocare and *Sudarshan Ghanvati*.
6	Nov 10		Overall improvement reported.
8	Nov 12	SpO2: 98, PR: 78 BP sys: 125-149 BP dias: 87-92	The patient reported that BP had increased the previous night, causing headache; still experiencing slight headache and feeling feverish (though temperature is normal); relief with respect to other symptoms. Yoga Nidra recommended.
9	Nov 13	SpO2: 97-98, PR: 75-82 BP sys: 119-136 BP dias: 90-93	Patient complained of high BP accompanied with headache - Ayurvedic medicine Cardiol H capsules (1 BD) added to the prescription for management of BP.
10	Nov 14	SpO2: 98, PR: 87 BP 127/99	Improvement reported in headache; no other symptoms.
13	Nov 17		Complete recovery reported.

Table 27 — Progress of patient P29 and evolution of the treatment plan

Day	Date	Vital Measures	General Remarks
0	Nov 07		Symptoms: body-ache, shivering, sore throat.
1	Nov 08	SpO2: 97-98, PR: 75-78 Temp: 99.7 BP: 125/90	Symptoms: Body-ache, weakness, throat irritation, sneezing; developed fever later during the day; eating properly.
2	Nov 09	SpO2: 98, PR: 90 Temp: 97.6 BP: 133/97	Mild cough developed; weakness and body-ache persist; nasal/chest blockage - steam inhalation suggested.
3	Nov 10		Patient started steam inhalation since the previous day. No more fever; mild cough and nasal/chest blockage persist; improvement in weakness and body-ache.
5	Nov 12	SpO2: 98-99, PR: 64-81 BP sys: 125-131 BP dias: 93-95	Improvement reported in nasal/chest blockage; relief from weakness and body-ache; mild cough persists. Overall 75% relief reported.
6	Nov 13	SpO2: 97-98, PR: 69-71 BP sys: 133-135 BP dias: 94-100	Much improvement in blockage. No more symptoms except mild cough.
7	Nov 14	SpO2: 99, PR: 82 BP: 124/94	Patient reported to have almost completely recovered. No more blockage as evident from the voice of the patient; mild seasonal cough remains.
10	Nov 17		Complete recovery reported.

Table 28 — Progress of patient P30 and evolution of the treatment plan

Day	Date	Vital Measures	General Remarks
0	Nov 06		Symptoms: fever, body-ache.
2	Nov 08	Temp: 99.3-101.0	Symptoms: fever, body-ache, weakness; SpO2 touching 95 - *Makarasana* and *Shithilasana* suggested.
3	Nov 09	SpO2: 95-97 Temp: 98.1-99.2	Mild fever; mild dry cough and mild weakness; no body-ache; reported to be sleeping and eating well.
4	Nov 10	SpO2: 96-97 Temp: 98.3-98.4	No more fever; improvement in cough; mild weakness persists. Overall 60% recovery reported.
5	Nov 11	SpO2: 95-96 Temp: 98.2-98.4	
6	Nov 12	SpO2: 96-97 Temp: 98.3-98.4	Mild cough remains; relief with respect to all other symptoms. Patient expressed determination to adopt yoga in his lifestyle.
7	Nov 13	SpO2: 96-97 Temp: 98.2-98.4	Condition same as before.
8	Nov 14	SpO2: 96-97 Temp: 98.3-98.4	
9	Nov 15	SpO2: 96-97 Temp: 98.3-98.4	Patient reported complete recovery.
10	Nov 16	SpO2: 96-97 Temp: 98.2-98.4	
11	Nov 17	SpO2: 96-97 Temp: 98.2-98.4	
12	Nov 18	SpO2: 95-96 Temp: 98.2-98.5	
13	Nov 19	SpO2: 96-97 Temp: 98.3-98.4	
14	Nov 20	SpO2: 95-97 Temp: 98.3-98.4	Patient continues to be in good health.