Ayurvedic Healing
Healing from Within

Initial Patient Form

DATE:

Personal Data:

Name: _____

Address: _____

City or Town: _____

State: _____ Zip Code: _____

Country:_____

E-mail address: _____

Telephone (home): _____

Telephone (cell): _____

Gender: ____ Male ____ Female ____ Other

Age_____ Birth date: _____Birth Time: _____Birth Place:_____

Marital Status: Married Single Divorced Widowed

Occupation: _____

What are your goals for your wellness consultation today?

Do you currently engage in any activities that could compromise your health or would be considered "unhealthy"?

Do you have any current health concerns or problems?

Any significant previous health concerns or problems?

Any significant family history of health problems?

Please list all prescription medications, birth control pills, hormone replacement therapy, vitamins or other supplements that you are taking:

_____

_____

_____

Please list foods you typically eat for:
Breakfast:

Lunch:

Dinner:

Snacks:

Any special dietary needs?

_____

Previous Ayurvedic evaluations and treatments:

_____

List date and place of most recent previous Ayurvedic evaluation, if any:

_____

List date and place of most recent in-residence Panchakarma programs, if any:

_____

Body Weight: _____

Height: ____ ft. ____ in. Weight: Now _____ , 1 year ago _____

Maximum_____ When? _____ Minimum _____ When? _____

Digestion:

1. Is your digestion: ___ Good ____ Fair ____ Poor
2. Is your appetite: ____ Strong ___ Moderate ___ Mild ___ Variable
3. In general, how is your energy during the day? ___ Strong ___ Medium ___ Low ___ Variable
4. Do you often feel heavy after eating? ___ Yes ___ No
5. Do you often feel sleepy after eating? ___ Yes ___ No
6. Do you have problems with (please circle):
   Gas flatulence belching bloating heartburn acid indigestion reflux
   Other:
7. Are there any foods that cause discomfort? _____

Elimination:

1. Do your bowel movements tend to be?
   ____ Regular ____ Irregular
2. How often do you have bowel movements?
   ____ More than 3 times a day ____ 2-3 times per day
   ____Once daily ____Less than once every 3 days
3. When do you usually have bowel movements?
   ____ First thing in the morning ____ Later in the morning ____ In the afternoon
   ____ Immediately after meals____At night after dinner
4. Stools are usually:
   ____Soft ____Medium ____ Hard ____ Variable consistency
5. Do you use enemas or laxatives?
   ____No ____ Yes How often? _____
6. Do you have hemorrhoids?
   ____ No ____ Yes If yes, do they bleed? _____

Diet and Eating Behavior:

1. Is your diet:
   _____ Non-vegetarian ____ Mostly Vegetarian ____Vegetarian
2. Which is your main meal?
   ____ Breakfast ____ Lunch ____ Dinner
3. Do you eat between meals? ____ Yes ____ No
4. How much time do you take for: Breakfast _____ Lunch_____ Dinner_____
5. Do you sit for 5-10 minutes after finishing a meal (circle one)? ____ Yes ____ No
6. Do you feel you now have or had in the past an eating disorder? ____ Yes ____ No
7. How often do you eat the following?
   a. Leftovers? ____ Often ____ Sometimes ____ Rarely ____ Almost never
   b. Frozen foods? ____ Often ____ Sometimes ____ Rarely ____ Almost never
   c. Packaged/processed foods? ____ Often ____ Sometimes ____ Rarely ____ Almost never
   d. Cold foods and/or drinks? ____ Often ____ Sometimes ____ Rarely ____ Almost never
   e. Raw vegetables (salad)? ____ Often ____ Sometimes ____ Rarely ____ Almost never
   f. Red meat? ____ Often ____ Sometimes ____ Rarely ____ Almost never
   g. Spicy foods? ____ Often ____ Sometimes ____ Rarely ____ Almost never
8. How many times per week do you eat out in a restaurant? _____
9. About what percentage of your food is organically grown? _____
10. How many soft drinks or diet soft drinks do you drink each week? _____
11. What kind of water do you drink? _____

Sleep:

1. Is your sleep disturbed?
   ____ Not at all ____ Somewhat ____ Moderately ____ Severely ____ Very Severely
2. Do you take sleep aids? _____
3. What time do you usually go to bed (lights out)?_____
4. What time do you usually wake up?_____
5. Are your bedtime and arising times regular from day to day?
   ____ Very Regular ____ Mostly regular ____ Somewhat regular ____ Mostly irregular

Daily Routine:

1. How regular is your daily routine (for example, do you go to bed, get up, and eat your meals around the same time daily)?
   ____ Very regular ____ Not very regular
   ____ Somewhat regular ____Very irregular
2. Do you go to bed early (by 10:00-10:30 p.m.)? ____ Yes ____ No
3. Do you get up early (by 6:00-6:30 a.m.)? _____ Yes ____ No
4. Do you eat your meals on time? ____ Yes ____ No
5. How often do you exercise?
   ____Regularly ____ Occasionally ____ Never
6. What type of exercise do you do, if any? _____
7. Is your exercise?
   ____Vigorous ____ Moderate ____ Light ____ None
8. Do you practice meditation? ____ Yes ____ No
   a. How often? ____ Regularly ____ Occasionally ____ Never
   b. What kind?_____
9. Do you take daytime naps? ____ Often ____ Sometimes ____ Rarely ____ Almost never 10. Do you travel a lot? ____ Yes ____ No
11. How often do you:
    a. Smoke: _____
    b. Drink alcohol: _____
    c. Drink caffeinated beverages: _____
12. Do you feel you take enough time for yourself? ____ Yes ____ No
13. How many hours per day do you use a computer? _____
14. How many minutes per day on a cell phone? _____
15. Are you having work or family problems that are impacting your health? ____ Yes ____ No
16. Do you perform "cleansings"? ____Yes ____ No Describe: _____

Psychology:

1. How would you describe your mood? _____
2. Do you suffer from? (circle relevant) anxiety, depression, anger, mood swings
3. Are you currently in psychological counseling? ____ Yes ____ No

Section for Women

Menstrual History:

Age of onset: _____

Date of last period: _____

Date of last GYN exam: _____ Any abnormalities? ____ Yes ____ No

(If yes, describe)_____

Do you take birth control pills? ____ Yes ____ No

Length of time taking: _____

1. Which of the following describes your menstruation? (Choose as many as apply)
   ____ Regular ____ Absent ____ Irregular ____ Too frequent
   ____ Infrequent ____ Ceased due to menopause

(If you are post-menopause, please skip to Question 5)

2. How many days does your menstrual period last?
   ____ Zero to four days ____ Five to seven days
   ____ More than seven days ____ Spotty/irregular

3. Is your menstrual flow?
   ____ Heavy ____ Light ____ Normal

4. Associated symptoms (before or during Menstruation):
   ____None ____ Fluid retention ____ Pain ____ Acne Other_____

5. Do you have any discharge outside of your menstrual period? ____ Yes _____ No

6. Do you have any itching of vaginal area?
   ____ Yes ____ No

Are you pregnant now? ____ Yes ____No ____ Don't know

Number of children:_____

Number of pregnancies: _____

Describe any complications with pregnancy:

_____

CANCELLATION POLICY

A $45 dollar fee will be charged without a 24 hour notice from the scheduled time of consultation or treatments.

Ayurvedic Wellness Consultation Agreement

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DATE: _____

- I understand and agree that this wellness consultation will be based on the principles of Ayurveda, an alternative approach to health, and that this consultation or any information I may gain are different from, and not a substitute for modern medical evaluation and treatment or preventative testing. (Blood test, Pap smears, colon screening, mammograms, and any other screening tests)
  _____ (Initial Here)

- I understand that Ayurveda uses a unique system with a valuation and health based on the concept of balance three doshas and overall tissue health. I understand that the consults purpose will be to assess the level of balance in the physiology and to make recommendations based on the Ayurveda health approach to health and enliven the inner intelligence of the body and restore balance to the physiology.
  _____ (Initial Here)

- I understand that this consultation and recommendations I will receive are not for the purpose of diagnosing or treating any disease that I may have.
  _____ (Initial Here)

- I understand that the pulse evaluation is for the purpose of assessing overall balance and is NOT for diagnosing the presence or absence of any particular disease.
  _____ Initial Here)

- I agree to consult with my family physician regarding all matters pertaining to any prescription medication or modern medical treatment that I may be taking.
  _____ (Initial Here)

- I recognize and agree that any advice or recommendations to me as the sole responsibility of the educator and no other person or organization.
  _____ (Initial Here)

Signature_____Date_____

Printed Name_____ Telephone_____

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