Go with the flow Ayurveda- Client Intake Form

Name:_____

Address:_____

City,Stat,:_____Zip ____

Telephone—Home:_____

Work:_____E-mail:_____

Birth date:_____ Birth place: _____Age:__

Marital/partner status:_____

# of children:_____Ages:_____

Occupation: _____ Blood type: _____

Height: _____

Weight: _____

How did you hear about Ayurveda? : Website/Referral/Friend/other.....

If in the past you had seen providers of alternative medicine/healers, please list the type of work they did (e.g. Acupuncture, Reiki, Energy Healing, etc.):

_____

_____

Are you allergic to any medications? YES ___ NO __If yes, please list the names of the medications and your reactions to them:_____

_____

Are you allergic to any materials or foods? (Example: Latex, Cat Dander, Peanuts)
If yes, please list the substances and your reactions to them:

_____

_____

Do you drink alcohol? How often? _____

Do you use Smoke? YES ----- NO ------

Former Smoker, Quit in year:_____

If yes, how many packs per day?_____ For how many years? _____

Ayurveda Diet and Lifestyle Coaching

Intention of Program: To educate you about your individual constitution and assist you in bringing yourself back to balance and harmony with the laws of nature. As you begin to move towards balance, you become more conscious and your natural, innate intelligence wakes-up, you begin to naturally make choices that are nurturing, healing, and balancing. You will be educated and empowered to take charge of your own health, and begin to develop the awareness to bring balance and health to each moment of your life, restoring you to your true joyful nature and present to the beauty and magic of life.

Outline of Services: 1 hour Consultation; an opportunity to assess your current physical, mental and spiritual routines, your prakruti (fundamental state of balance) and your vikruti (current imbalance). I will begin to educate you on your individual constitution and the basics of Ayurveda. You will be introduced to new practices as part of your plan for achieving balance. Practices may include meditation, yoga, dietary adjustments and breathing exercises all designed to further your education, awareness and ability to bring balance to your life.

Seasonal transition 45 min. follow-up sessions will be recommended to monitor and support your progress. In this way you can integrate lifestyle changes over time and we can make any adjustments needed in your program. Ayurveda is not about instantaneous results, although you will see many immediate benefits. In accordance with the laws of nature, it will take time to gently restore full balance. Life is dynamic and we are part of

life. We continually need to modify our lifestyle to the changing seasons, emotions, stresses etc. to achieve balance. Ayurveda is not a passive form of therapy but rather asks each individual to take responsibility for his or her own daily living. Using the ancient wisdom of Ayurveda I will educate, empower and support you as a dynamic individual, but it is up to you to bring this into your daily life. It is a simple, natural science that takes time, as it takes time for the stream to wear the stone smooth, but gently, over time it changes form completely. It is amazing the difference a small adjustment in your diet or lifestyle can make to create greater well-being. I am excited and honored to assist you in discovering your uniqueness and create a balanced life with radiant health and a peaceful mind.

Requirement of Client:

24-Hour Cancellation Notice. Less than 24 hours notice will require a $20.00 rescheduling fee.

Payment of Ayurvedic Consultation is $100.00. Payment is expected in full during our initial Ayurvedic Consultation.

Client Signature: _____

Ayurvedic Practitioner: _____

Date:_____

Please take quiet time and space to answer these questions. Take this as an opportunity to bring awareness to areas of your life that may need more loving attention. Use a separate sheet of paper if needed.

1. *What are you currently doing in your life that brings you peace, health, balance and/or nurtures your soul?*

   _____

2. *What would you like to get out of the Ayurvedic Consultation?*

   _____

   _____

CHIEF HEALTH CONCERNS

What are your main health concerns at this time? Order by importance to client.

PRIMARY CONCERNS	***CLINICIAN NOTES***
□□	
□□	
□□	
□□	
□□	
□□	

Do you have a present or past history of:

COPD

CHF

Anemia. If yes, list type:

Arthritis. If yes, list type:

Asthma

Depression

Anxiety

Autoimmune Disorders. If yes, list type:

Cancer.

Congenital Heart Disease/ Coronary Artery Disease

Diabetes. If yes, circle type:

Eczema

Type I

Type II

Glaucoma

Inflammatory Bowel Disease

MI/Heart Attack

Heart Arrhythmia

Heart Murmur

Heart Valve Disorder

Hepatitis or Liver Disease

High Blood Pressure

Hypothyroidism

Hyperthyroidism

Hay Fever/Seasonal Allergies

Lyme Disease

Migraines

Multiple Sclerosis

Pacemaker

Peptic Ulcers

Psoriasis

Rheumatic Fever

Seizure Disorders

Sleep Apnea

Stroke or Transient Ischemic Attacks

Tuberculosis

Prolonged Steroid Therapy or other Immune Deficiency State?

Issues with Prolonged Bleeding?

Please circle if you have been diagnosed with any of the following: Irritable Bowel Disease, Chronic Fatigue/CFIDS, Fibromyalgia, or Environmental Sensitivity

Any other issues?

_____

_____

Please list any past surgeries you have had:

_____

_____

Please list any hospitalizations that you have had (do not include visits to the ER):

_____

_____

FAMILY HISTORY: **Has anyone in your immediate family had any of the following? Write the relation of the relative on the line (e.g. brother, sister, mother, etc.)**

*Diabetes:*_____

*Coronary Artery Disease:*_____

*Hypertension:*_____

*Substance Abuse:*_____

*Neurological Disease:*_____

*Inflammatory Bowel Disease:*_____

Heart Attack before age50:_____

Cancer: _____

Stroke: _____

Peripheral Artery Disease:_____

Other: _____

Please list all current doctor-prescribed medications: **Name, Strength, Dosage**

(Example: **Name:** Metformin **Strength:** 1000mg **Dosage:** One pill twice daily)

_____

_____

_____

_____

_____

_____

_____

_____

Please list all current herbal or alternative supplements: **Name, Strength, Dosage**

(Example: Arnica 30X, 5 pellets 3 times daily)

_____

_____

_____

_____

For Women:

If sexually active, what is your method of birth control? _____ Number of pregnancies:_____ Number of Live Births:_____

Age when periods started: _____ Age when periods ended (if applicable):_____ Are your periods regular or irregular? _____ Pain or heavy bleeding during periods?_____ Premenstrual Symptoms?_____

What types of food(s) are eaten on a regular basis?

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

Are there any routines around eating:Please explain?

Daily Routine

Describe your activities from the time you wake up until you go to sleep. (Eating, sleeping, exercise, work, activities).

_____

_____

_____

How many cups of caffeinated beverages do you drink per day?

_____ Type(s) of beverage: coffee/tea/soda

How many cups of non-caffeinated beverages do you drink per day?

_____

Type(s) of beverage: herbal tea/milk/juice/other

_____

How much water do you drink per day ?

_____

Do you exercise regularly?

Length of time:_____

Times per week: _____

Type(s) of exercise: _____

Any current or past problems with addiction or substance abuse? Y /N

Substance: _____ Amount: _____

When quit? _____

Please describe current digestive patterns (i.e. regular/irregular B.M., diarrhea, constipation, indigestion, strong/dull appetite):

_____

_____

__

Body temperature: Do you generally run warm or cold? Please explain:

_____

—

Examination- (For Practitioner to fill)

PRAKRUTI (pulse deep level): (eg. V.. P.. K..)

VIKRUTI (pulse superficial level): (eg. V2 P3,5 K2)

FACE & TONGUE general overlook:

Eyes-

Skin-

DHATU: rasa, rakta, mamsa, meda, asthi, majja, shukra/ artava.-

Blood-pressure -

Notes:-