Ayurveda Wellness Healing

"Blockage is disease, flow is health"

Confidential Client History

Name: _____
Address: _____
City: _____ State:_____ Zip:_____

Telephone -
Home:_____Work:_____Cell:_____

Email:_____ Birth date :_____

Age:_____ Marital Status: _____No. of Children: _____

Occupation_____

How did you hear about Ayurveda Wellness Healing ? [ ] Website [ ] Newspaper Ad
[ ] Referral [ ] Other_____

Objectives
Please check the items that reflect your main Objectives:
[ ] I want an alternative approach to allopathic medicine for managing illness and disease.
[ ] I want to improve my general health and wellness and reduce my vulnerability to illness.
[ ] I want to improve my lifestyle and dietary practices to improve my health.
[ ] I want to change my habits and behavioral patterns to improve my relationships with others
[ ] I want to manage stress, tension and worry to attain a more stable emotional nature.

Review of Concerns
List your chief complaint and any other significant symptoms that you are concerned about. If you have been diagnosed with any disease or condition, list them as well.

Health
Concerns:_____
_____
_____
_____
_____
_____
_____
_____
_____

Diagnosed
Conditions:_____
_____
_____
_____
_____
_____
_____

Please check the digestive, elimination and emotional challenges that you experience. Indicate your current conditions by (C) and occasional conditions by (O) in each category.

Digestion
[ ] abdominal Pain [ ] Burning Indigestion [ ] Nausea/Vomiting
[ ] Excessive Gas [ ] Heartburn [ ] Sluggish after eating
[ ] Belching [ ] Smelly Gas [ ] Sleepy after eating
[ ] Bloating [ ] Other: [ ] Other:

Elimination
[ ] Constipation/Irregular [ ] Regular/Soft Stool[ ] Regular/Oily/Mucus in Stool
[ ] Diarrhea

Psychology
[ ] Worry/Anxiety [ ] Irritable/Anger [ ] Lethargy/Slow Pace[ ] Fear [ ] Rage
[ ] Depression [ ] Fog [ ] Jealousy/Envy [ ] Over Attachment
[ ] Insomnia/light sleep [ ] Moderate Sleep (6-8hrs) [ ] Heavy sleep (8-10 hrs)
[ ] Indecisive/Quick in making decisions [ ] Decisive and focused [ ] Slow in making decisions but steady [ ] Changeable
[ ] Flying or fearful dreams [ ] Violent, fiery Dreams [ ] Romantic, watery dreams, swimming

Comments regarding symptoms above

_____
_____
_____
_____
_____

General Health and Lifestyle Patterns

1. *Do you exercise regularly*? [ ] yes [ ] no Length of time: _____
times per week: _____

2. *How much of the following do you drink*? (Note: 1 cup = 8 ounces)
Water No. of cups per day: _____
Non-caffeinated beverages: No. of cups per day: _____
types Herbal tea/milk/juice/other _____
Caffeinated beverages: No. of cups per day: _____
types: Coffee/tea/soda _____
Alcohol: No. of cups per : day/week/month (please circle)._____

3. *Do you currently smoke*?
[ ] No [ ] Yes - How may cigarettes per day? _____How long have you smoked? ____
Have you ever smoked? [ ] yes [ ] no. If yes, when did you quit? _____

4. *Any current or past use of addictive substances*? [ ] yes [ ] no [ ] quit, when? _____

5. *Do you experience allergic reaction to any substance*s (food, drugs, environmental etc.) Please explain:_____
_____
_____

6. *What type of work do you do*:_____

7. *Please circle your work level of stress* – (1 = least, 5= most): 1 2 3 4 5

8. Level of work satisfaction: 1 2 3 4 5

9. *Are you currently experiencing stress in any close relationship*?
If yes, level of emotional stress: 1 2 3 4 5

10. *Are you sexually active*? [ ] yes [ ] no Libido (1 =least, 5=most):1 2 3 4 5
Level of satisfaction: 1 2 3 4 5

11. *Do you have any specific spiritual practices*? Please describe:-
_____
_____

Dietary Patterns
What kind of taste do you prefer? Please circle one of the following:

Sweet Sour Salty Pungent Bitter Astringent

Any current or past chronic eating disorders or other food related issues? [ ] yes [ ] no Please indicate your primary food choices and meal times:

Meals Time(s) Typical foods and Beverages
Breakfast Time: _____
Breakfast foods_____
_____

Lunch time:_____
Lunch foods_____
_____

Dinner Time;_____
Dinner foods
_____
_____

Snacks
How often during day_____
_____
_____

Current Medications, Herbs or Supplements
What medications are you currently taking or have taken recently, including birth control and

Hormone replacement therapy.

Are you currently taking any Herbal Remedies or Supplements? Please list:

For Women Only

Is there any possibility that you are pregnant ( ) Yes ( ) No

Menstrual History Please check:
Your period is/was [ ] Heavy [ ] Light Period
Cycle [ ] 28 days [ ] 30 days [ ] other, please describe:
Menopause:
Do you have any pre/post- menopausal symptoms? Please describe:
_____
_____

Medical History
Personal History:
Do you or your parents (indicate by P) have a history of: (check ailments that apply)

Allergies to foods or drugs [ ] yes [ ] no
Heart surgery [ ] yes [ ] no
Anemia [ ] yes [ ] no
Hepatitis A [ ] yes [ ] no
Arthritis [ ] yes [ ] no
Hepatitis B [ ] yes [ ] no
Asthma, Pneumonia, TB [ ] yes [ ] no
Blood Pressure, high/low [ ] yes [ ] no
HIV Exposure [ ] yes [ ] no
Cancer [ ] yes [ ] no
Frequent attacks of colds /coughs [ ] yes [ ] no
Chronic Constipation [ ] yes [ ] no Chronic Diarrhea [ ] yes [ ] no
Chemotherapy/ Radiation [ ] yes [ ] no
Kidney or Bladder disease [ ] yes [ ] no
Chest Pain [ ] yes [ ] no
Mental Disorder [ ] yes [ ] no
Cholesterol, elevated [ ] yes [ ] no
Jaundice, Gallstone [ ] yes [ ] no
Dental complications [ ] yes [ ] no
Ear pain or ringing [ ] yes [ ] no
Diabetes [ ] yes [ ] no
Dizziness [ ] yes [ ] no
Prolonged bleeding when cut [ ] yes [ ] no
Epilepsy, convulsions, seizures [ ] yes [ ] no
Rheumatic Fever [ ] yes [ ] no

Fainting [ ] yes [ ] no
Sinusitis [ ] yes [ ] no
Feet or ankle swelling [ ] yes [ ] no
Shortness of Breath [ ] yes [ ] no
Glaucoma, eye surgery [ ] yes [ ] no
Stroke [ ] yes [ ] no
Heart Attack [ ] yes [ ] no
Thyroid disease [ ] yes [ ] no
Heart disease/ Heart murmur [ ] yes [ ] no
Ulcers, Intestinal bleeding [ ] yes [ ] no
Implant/Prosthesis [ ] yes [ ] no
Venereal Diseases [ ] yes [ ] no

Please explain any items checked
:_____
_____
_____

Any Other Disease or Problems not listed above:

Have you been under the care of a licensed health care practitioner in the past year? [ ] yes [ ] no If yes, for what reasons:

Date of last physical exam _____

Any past history of:
[ ] Serious injuries
[ ] Stress
[ ] Trauma
[ ] Fatigue
[ ] Emotional/Mental stresses
[ ] Mental Clarity/Concentration
[ ] Troubled lifestyle conditions
[ ] Vision problems, including dry eyes
[ ] Changes in weight
[ ] Hot flashes
[ ] Aches, pains
[ ] Cosmetic surgery

Please describe any items checked

_____
_____
_____

Ayurveda Wellness Healing

INFORMED CONSENT TO RECEIVE AYURVEDA CONSULTATION

All clients who participate in Ayurveda Wellness Healing should be advised of the following information:

1. Ayurveda is the traditional healing system from India, and is based on the idea that each person s path toward optimal health is unique. Your program is based on an understanding of your unique constitution and the unique nature of your imbalance. Your program may include lifestyle adjustments, dietary changes, herbs, yoga and meditation, Ayurveda therapies, aromatherapy and therapeutic massages. The goal of all programs is to create within your body and mind an optimum environment for healing to take place and to maximize your body s ability to heal itself.
2. Ayurveda Wellness Healing is not a medical facility.
3. Employees of Ayurveda Wellness Healing are not trained in Western diagnosis or treatment and may not make suggestions about altering your medical care unless a Licensed Physician is being consulted.
4. The National Institute of Health Office of Complementary and Alternative Medicine currently considers Ayurveda a form of complementary and alternative medicine in the United States.
5. If you are suffering from a disease or symptom that has not been evaluated by a Medical Doctor or another licensed health care professional, we recommend that you receive a proper evaluation from your medical provider.
6. No one in association with Ayurveda Wellness Healing may recommend altering your prescriptions without the approval of your medical doctor..
7. The following services are Not offered by Ayurveda Wellness Healing: Diagnosis, Treatment or advice of pathological conditions, prescription drugs or medicine.

I have read and understand the above information and give my permission to begin a program of Ayurvedic Wellness Healing.

Client Signature:_____ Date:_____