Ayurvedic Healing
3121 Park Ave Ste D, Soquel, CA 95073 phone 831.462.3776 fax 831.462.3706 www.ayurvedichealing.net

Confidential Client History

Name: _____

Address: _____

City, State, Zip: _____

Telephone - Home:_____Work:_____Cell:_____

Email:_____ Birth date :_____

Age:_____ Marital Status: _____ No. of Children: _____

Occupation: _____

Is there any possibility that you are pregnant? ☐ Yes ☐ No ☐ Possible

Are you nursing? ☐ Yes ☐ No

Family Physician: _____

How did you hear about Ayurvedic 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 and disease

☐ 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:

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 listed 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

3. *Do you currently smoke*?

☐ Yes - How may cigarettes per day? _____How long have you smoked? _____

☐ No – 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 substances* (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): Level of satisfaction:

8. *Are you currently experiencing stress in any close relationship*?

If yes, level of emotional stress:

9. *Are you sexually active*? ☐ yes ☐ no Libido (1 =least, 5=most):

Level of satisfaction:

10. *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: _____

Lunch: _____

Dinner: _____

Snacks: _____

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

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
Anemia ☐ yes ☐ no
Arthritis ☐ yes ☐ no
Asthma, Pneumonia, TB ☐ yes ☐ no
Blood Pressure, high/low ☐ yes ☐ no
Cancer ☐ yes ☐ no
Chronic Constipation ☐ yes ☐ no
Chemotherapy/ Radiation ☐ yes ☐ no
Chest Pain ☐ yes ☐ no
Cholesterol, elevated ☐ yes ☐ no
Dental complications ☐ yes ☐ no
Diabetes ☐ yes ☐ no
Dizziness ☐ yes ☐ no
Epilepsy, convulsions, seizures ☐ yes ☐ no
Fainting ☐ yes ☐ no
Feet or ankle swelling ☐ yes ☐ no
Glaucoma, eye surgery ☐ yes ☐ no
Heart Attack ☐ yes ☐ no
Heart disease/ Heart murmur ☐ yes ☐ no
Implant/Prosthesis ☐ yes ☐ no
Heart surgery ☐ yes ☐ no
Hepatitis A ☐ yes ☐ no
Hepatitis B ☐ yes ☐ no
Hepatitis Non-A/Non B ☐ yes ☐ no
HIV Exposure ☐ yes ☐ no
Frequent attacks of colds /coughs ☐ yes ☐ no
Chronic Diarrhea ☐ yes ☐ no
Kidney or Bladder disease ☐ yes ☐ no
Mental Disorder ☐ yes ☐ no
Jaundice, Gallstone ☐ yes ☐ no
Ear pain or ringing ☐ yes ☐ no
Jaw pops, clicks or locks ☐ yes ☐ no
Prolonged bleeding when cut ☐ yes ☐ no
Rheumatic Fever ☐ yes ☐ no
Sinusitis ☐ yes ☐ no
Shortness of Breath ☐ yes ☐ no
Stroke ☐ yes ☐ no
Thyroid disease ☐ yes ☐ no
Ulcers, Intestinal bleeding ☐ 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
- ☐ Trauma
- ☐ Emotional/Mental stresses
- ☐ Troubled lifestyle conditions
- ☐ Changes in weight
- ☐ Aches, pains
- ☐ stress
- ☐ Fatigue
- ☐ Mental Clarity/Concentration
- ☐ Vision problems, including dry eyes
- ☐ Hot flashes
- ☐ Cosmetic surgery

Please describe any items checked:

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INFORMED CONSENT TO RECEIVE COMPLEMENTARY HEALTH CARE

All clients who participate in Ayurvedic Health Care 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 your unique constitution and the unique nature of your imbalance. Your program may include lifestyle adjustments, dietary changes, herbs, yoga and meditation, Ayurvedic 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. Ayurvedic Healing LLC is not a medical facility.
3. Employees Ayurvedic Healing of Ayurveda LLC 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. In the State of California, Ayurveda is a non-licensed profession. Its practice was formally legalized under the passage of Senate Bill 577 in January 2003. Ayurvedic Consultations are considered alternative or complementary to healing arts that are licensed by the State of California.
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 and may provide you with a referral form. If you are referred to a medical Doctor, you will be required to go or sign an acknowledgement that one was recommended to you.
6. No one in association with Ayurvedic Healing LLC may recommend altering your prescriptions without the approval of your medical doctor. Your Practitioner may suggest that you speak to your doctor about reducing medications when he/she feels that it is appropriate.
7. While your Practitioner may take your blood pressure and vital signs, and perform some examination techniques similar to a routine medical examination, your Practitioner is evaluation their findings from an Ayurvedic perspective only and not from a Western medical perspective. This examination does not take the place of a medical evaluation. If, as a result of this examination, any finding suggestive of a possible medical condition is found, your Practitioner will refer you to a Medical Doctor for further evaluation.
8. The following services are Not offered by Ayurvedic Healing LLC unless under direct supervision of a Medical Doctor: 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 Health care with Ayurvedic Healing, LLC.

Client Signature: _____ Date: _____

Witness: _____