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Confidential Client Intake Form

Name:_____

Address:_____

City, State, Zip _____

Tel. Home:_____ Cell:_____ Work:_____

Email:_____ Birthdate:_____ Age: _____

Birthplace:_____ Place of Childhood: _____

Marital/Partner Status:_____ # of Children:_____ Ages: _____

Occupation: _____

How did you hear about
Embrace Ayurveda?_____

May we add your email address to our eNewsletter list? We typically send 1-2 emails per month. D Yes D No

WHAT YOU CAN EXPECT FROM YOUR AYURVEDIC HEALTH CARE

Ayurveda is an ancient healing system from India which recognizes that each person's path toward optimal health is unique. The intention of the Ayurvedic Consultation is to educate you about your individual constitution and assist you in bringing yourself back to balance and harmony with the laws of nature. Ayurveda is not a passive form of therapy but rather asks each individual to take responsibility for his or her own daily living.

You will be introduced to new practices as part of your program for achieving balance. Your program may include meditation, yoga, dietary adjustments, breathing exercises, Ayurvedic treatments and cleansing therapies. A follow-up program will be recommended to support you in successfully integrating these practices into your life. You will begin to develop the awareness to bring balance and health to each moment, restoring you to your true joyful nature.

Agreements:

1. Payment of Ayurvedic Consultation is $185.00 which includes an initial 1.5 hours consultation and 1-hour follow-up session.
2. 24-Hour Cancellation Notice. If you miss an appointment with your practitioner without giving 24 hours notice, you will be charged full value for the appointment.
3. Payment is expected in full during our initial Ayurvedic Consultation. Payment can be made by cash, check or major debit/credit card.
4. Ayurveda Seattle does not bill insurance companies for any service.

Client's Signature:		Date:	

Informed Consent

To receive alternative health care through Ayurveda Seattle. All clients who participate in Ayurvedic health care through Ayurveda Seattle should be advised of the following:

1. Ayurveda Seattle is not a primary care medical clinic.
2. Your Ayurvedic Practitioner is not a Medical Doctor, is not trained in Western medical diagnosis, and may not prescribe or alter your medication.
3. Your practitioner is evaluating your findings from an Ayurvedic perspective. This examination does not take the place of a medical evaluation.
4. I understand there will be no diagnosis made or prescription given, but the Ayurvedic Practitioner will offer an assessment of my general health and will make dietary, herbal and nutritional recommendations.
5. I take full responsibility for my health and well-being and freely choose to incorporate any recommendations at my own discretion.

I have read and understand the above information.

Client's Signature:		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.

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?
3. If you achieved a perfect state of health, what would your life look like? How would you feel? What would you be doing? What would be different? Paint a picture for yourself.
4. How can I best support you in achieving the health, clarity, and balance you want in your life?
5. Is there anything you know you need to give up or bring in to have the results you want?

Health Concerns

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

1.	
2.	
3.	
4.	
5.	
6.	

Past Medical History

Please list any major condition(s) and dates of diagnosis, treatment, and procedures performed.

Are you under the care of a licensed health care professional or any other healthcare provider? D Yes D No

If so, for what reason(s)? _____

_____

Serious Illnesses: _____

_____

Hospitalizations: _____

List other pertinent current or past conditions: _____

Have you had any cosmetic or dental surgery or other procedures performed? D Yes D No

If so, please list: _____

Family History

Indicate which members of your immediate family have had these conditions.

High Blood Pressure		**Heart Disease**		**Other**	
Cancer		**Mental Disorder**			
Stroke		**Diabetes**			
Notes:					

Current Medications, Herbs, or Supplements

What medications, herbs, and supplements are you currently taking? Please include signiftcant remedies that you have stopped taking, including birth control and hormone replacement therapies.

Substance	Over-the-Counter or Prescription?	Herb/Drug/ Vitamin?	Prescribed by? (ie: self, MD)	For what purpose?	For how long?	What dosage?	What have the benefits been?

Regular Practices

Exercise _____

D None/Never D Occasional D Several Times/Week D Daily D Several Times/Month

Yoga _____

D None/Never D Occasional D Several Times/Week D Daily D Several Times/Month

Spiritual Practices (specify) _____

D None/Never D Occasional D Several Times/Week D Daily D Several Times/Month

Travel (include commute if applicable) _____

D None/Never D Occasional D Several Times/Week D Daily D Several Times/Month

Daily Schedule

What are your habitual activities from the time you wake up until you go to sleep? Include mealtimes, sleeping, exercise, work, and any activities that occur on a regular basis.

	Time	Habitual Activities	Notes
Morning			
Awaken			
Mealtime			
Activities			
Day			
Mealtime			
Activities			
Night			
Mealtime			
Activities			

Habits

Are you a smoker? D Yes D No Years?_____Amount? _____

Have you smoked in the past? D Yes D No When did you quit?_____

Do you use recreational drugs? D Yes D No If yes, what types?_____How often?_____

Do you drink alcohol? D Yes D No If yes, what types?_____How often?_____

Do you drink coffee? D Yes D No Cups/day? _____

Do you drink caffeinated/herbal tea? D Yes D No Cups/day? _____

Do you make a point to drink water daily? D Yes D No Glasses/day? _____

Any current or past addictive or habitual substances?

D Yes D No Specify: _____

Daily Nutrition

What types of food are eaten on a daily basis?

Breakfast	
Lunch	
Dinner	
Snacks	
Eating Routines?	

Allergies or Sensitivities

Do you have allergic reactions to any substances (including pollen, food, medicines)? If yes, please list:
Are there any foods you regularly avoid eating because they give you symptoms? If so, how long after eating do symptoms occur?

Gastro-Intestinal

- D Nausea
- D Vomiting
- D Diarrhea
- D Constipation
- D Black stools
- D Bad breath
- D Indigestion
- D Abdominal pain
- D Heartburn
- D Gas
- D Blood in stools
- D Mucous in stools
- D Rectal pain
- D Hemorrhoids
- D Bloating
- D Food cravings
- D Poor appetite
- D Gallstones
- D Ulcers
- D Difficulty swallowing
- D Colitis/IBS
- D Liver problems

Elimination

How many bowel movements do you have a day? D <1 D 1 D 2 D 3 D 4+

How would you describe your bowel movements? D loose D normal D hard D tarry

Do your stools: D float D sink D have a bad odor D have no odor D display blood?

Do you rely on: D enemas D laxatives D purgatives for bowel elimination?

If yes, how often? (Times per week?) _____

Any other digestive problems? _____

Any current or past chronic eating disorders or other food related issues? D Yes D No

Explain: _____

Appetite (Agni)

- D Variable: Sometimes I'm not hungry, but if I don't eat, I get low blood sugar, light-headed, dizzy or shaky.
- D Sharp: Ravenous, I have to eat now! I get irritable if I don't eat.
- D Dull: I like to eat. No big deal if I skip a meal.
- D Sama: Steady, consistent appetite at meal times. I feel satisfied after a meal.

Time of day you're most hungry: _____

Energy

D High D Low D Variable D Dips

How much energy do you have? Scale of 1-10:_____

Does it change? D Yes D No Do you take naps? D Yes D No How often?_____ How long?_____

Describe any energy issues you have?_____

Sleep Patterns

Describe your sleep patterns

What time do you regularly go to bed? _____ What time do you regularly go to sleep? _____

Is it easy to fall asleep? D Yes D No

Is it easy to get up in morning? D Yes D No

Do you get hot while sleeping? D Yes D No

Do you wake during the night? D Yes D No How often?_____ What time? _____

Is it easy to go back to sleep? D Yes D No

Describe any sleep issues you have:

_____

If you experience sleep challenges what do you think is the primary cause?

_____

Vitals

Height:_____ Weight: _____ Has it changed in the last year? D Yes D No

Most comfortable weight?_____

Body Temp: D warm D cool D variable D steady

Cold hands and feet? D Yes D No

Easily flush? D Yes D No

Overheat? D Yes D No

Blood pressure: D low D high D normal?

Mind, Emotions and Relations

How do you feel about the following areas of your life? Please check appropriate boxes.

	Excellent	Good	Fair	Poor	Comment
Self esteem					
Spouse/Partner					
Sex					
Family					
Life Purpose					
Finances					
Work					
Enthusiasm for life					

Are you able to express your feelings and emotions easily? D Yes D No

How would you rate your stress level on a scale of 1-10?_____

Is there something you are not doing that you have been wanting to do for a long time or something you are doing that you know is depleting your energy?

_____

Female Reproductive

D Discharge, if yes what is the color? _____

D Genital herpes	D Vaginal itching	D Pain with intercourse
D Cervical dysplasia	D Anemia	D Tubal ligation
D Endometriosis	D Pelvic inflammatory disease	D Mastectomy
D Uterine cysts	D Infertility	D Lumpectomy
D Fibroids	D Hysterectomy	D Vaginal infection

Do you have premenstrual symptoms (PMS)? D Yes D No

How many days before your cycle do symptoms begin to manifest?_____days before period

If you have PMS, which symptoms apply to you?

D Anxiety	D Fatigue	D Poor memory
D Nervousness	D Dizziness	D Grief
D Mood Swings	D Headaches	D Confusion
D Nervous tension	D Bloating	D Insomnia
D Craving for sweets	D Weight gain	D Lower back pain
D Increased appetite	D Water retention	D Abdominal pain
D Palpitations	D Depression	D Joint pain

Do you menstruate? D Yes D No

What is the length of your cycle?_____days. Duration of bleeding?_____days.

Would you characterize your flow as: D Heavy D Normal D Light

Is the blood: D Dark D Normal D Light

How many: pregnancies have you had?_____

Births?_____ Miscarriages?_____ Premature births?_____ Abortions?_____

Do you or have you recently used contraceptives? D Yes D No

If yes, which ones?

_____

If you have menopausal symptoms, please describe your major symptoms:

_____

Do you have any other gynecological issues?

_____

Health Concerns:

Please check off those issues you have experienced in the last 3 months.

Skin and Hair

- D Rashes
- D Itching
- D Pimples
- D Hair loss
- D Poor healing sores
- D Eczema
- D Acne
- D Recent moles
- D Hives
- D Psoriasis
- D Dandruff
- D Recent changes in skin texture

Any other noted problems with your skin, nails or hair?_____

Head, Eyes, Ears, Nose and Throat

- D Poor vision
- D Grinding teeth
- D Glaucoma
- D Jaw pain
- D Earaches
- D Dizziness
- D Sore throat
- D Cold sores, if yes how often?___times/year
- D Cataracts
- D Clicking jaw
- D Eye pain
- D Nosebleeds
- D Ringing in ears
- D Swollen glands
- D Floaters
- D Facial pain
- D Blurred vision
- D Mucous in throat
- D Poor hearing
- D Frequent colds
- D Canker sores

Any other problems with your head, eyes, ears, nose or throat? _____

Cardiovascular

- D High blood pressure
- D Fainting
- D Ankle swelling
- D Varicose veins
- D Low blood pressure
- D Irregular heart beat
- D Palpitations
- D Blood clots
- D Chest/heart pain
- D Cold hands or feet
- D Easy bruising
- D Breathing difficulties

Any other problems with your heart or circulation? _____

Respiratory

- D Hay-fever
- D Asthma
- D Pain on breathing
- D Difficulty breathing when lying down
- D Cough
- D Coughing blood
- D Shortness of breath without exertion
- D Production of phlegm, if yes what color?_____
- D Bronchitis
- D Pneumonia

Any other problems with breathing? _____

Genito-urinary

- D Painful urination
- D Urgency of urination
- D Inability to hold urine
- D Burning urine
- D Prostate enlargement
- D Frequent urination
- D Kidney/bladder stones
- D Decrease in flow
- D Difficulty stopping or starting
- D Erectile dysfunction
- D Blood in urine
- D Irregular flow
- D Water retention
- D Interstitial cystitis

Any other problems with urination? _____

Musculoskeletal

- D Neck pain
- D Back pain
- D Reduced range of movement
- D Muscle pain
- D Muscle weakness
- D Stiffness
- D Broken bones

Neuropsychological

- D Poor sleep
- D Depression
- D Seizures
- D High stress levels
- D Difficulty concentrating
- D Poor memory
- D Irritability
- D Migraine
- D Loss of balance
- D Foggy or spacey feeling
- D Numbness
- D Anxiety
- D Headaches
- D Lack of coordination
- D Muscle spasm/twitching

Do you have any other neurological problems? _____

Metabolic

- D Chronic fatigue
- D Night sweats
- D Sudden energy drops
- D Recent weight loss
- D Fevers
- D Excessive thirst
- D Intolerance to heat or cold
- D Chills
- D Slow metabolism
- D Recent weight gain

Thank you!