 ayurveda intake form

Date



personal information

First name



Last name



Date of birth



Address



|  |  |  |
| --- | --- | --- |
| City | State | Zip code |
| Cell phone | Home phone |  |
| Work phone | E-mail |  |
| Current occupation |  |  |
| Emergency contact | Phone number |  |
| program information |  |  |

Why are you interested in an Ayurvedic consultation?



present health

Please describe your present health problems and their duration. 1.



2.



3.



 ayurveda intake form

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| How long have you had the chronic conditions about which you are consulting us? | | | |  |
| Less than 6 months | 6 months to 2 years | 2–5 years | more than 5 years | |
| How have your health problems progressed since they began? | |  |  |  |
| Stable | Gradually improving | Rapidly improving | | Fluctuating |
| Gradually worsening | Rapidly worsening |  |  |  |
| Please indicate the overall intensity of your symptoms. | |  |  |  |
| Mild | Moderate | Severe |  | Very severe |
| How often are you having pain or discomfort? | |  |  |  |
| Less than once per week | Several times per week | |  | Once a day |
| Several times per day | Most of the time |  |  |  |



Do you take any nonprescription drugs or vitamins or any other supplement/s? Please list them.



Are you currently under the care of a family physician or any other health professional?



If yes, include details.



Do you currently take medication and/or receive medical treatment for your health condition(s)?



If so, include all medications, treatments, and dosages.



Do you have any past medical history or problems (i.e., illness, trauma, emotional stress, addictions, drug abuse, or anything else that will help us clearly understand your health condition)?

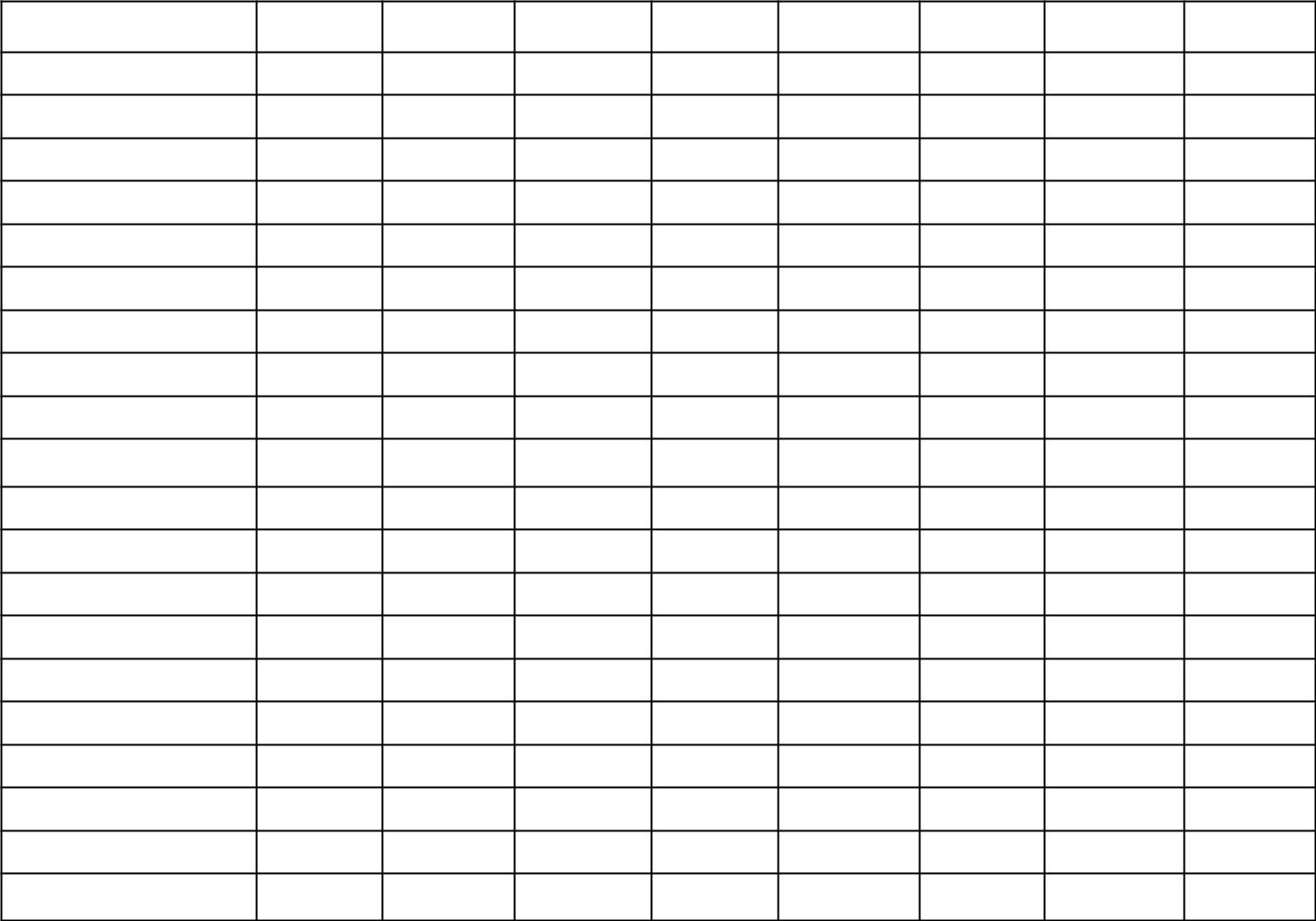


Is there a family history of the health problem(s) listed above?  Yes  No If yes, please specify.



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Fill in as appropriate.



|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| child | myself | father | motherbrother(s)sister(s) | spouse | other |

Age (if living)

Age (at death)

Cause of death

Anemia

Cancer

Diabetes

Epilepsy

Glaucoma

Heart disease

High blood pressure

Hay fever

Hives

Kidney disease

Mental illness

Rheumatoid arthritis

Tuberculosis

Syphilis

Stroke

Other

Any other family illnesses or concerns?



|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Health as a child: | Good | Fair | Poor |  |
| Childhood illnesses: | German measles | Measles | Mumps | Bronchial problems |
|  | Scarlet fever | Diphtheria | Other |  |
| Immunizations/vaccinations: | Smallpox | Polio | Typhoid | Mumps |
|  | Tetanus | Influenza | Other |  |



Have you ever experienced a reaction to vaccination(s)?



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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| daily routine (dinacharya) |  |  |  |  |
| Do you get up early? | Yes | No | At what time? |  |
| Do you go to bed early? | Yes | No | At what time? |  |
| Do you sleep during the day? | Yes | No | At what time? |  |
| How do you generally feel when you wake up in the morning? | | | |  |
| Fresh and rested | A little tired | | Moderately tired | Very Tired |
| In what direction does your head point during sleep? | | | |  |
| North | East |  | South | West |
| Northeast | Northwest | | Southeast | Southwest |



|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| How would you describe your experience of sleep? | | | |  |  |
| Sound; normal duration | | Light, interrupted | | Not enough | |
| Too heavy and/or long | | Difficulty falling asleep | | Difficulty waking up | |
| Awaken too early |  | Frequent nightmares | |  |  |
| What position do you sleep in? | |  |  |  |  |
| On back | On stomach | | Left side | Right side | Other |



How regularly do follow your ideal routine (i.e., go to bed early, eat meals on time, exercise regularly)?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Very regularly | Somewhat regularly | | | Irregularly | |
| Describe your bowel movements. |  |  |  |  |  |
| Once every 2–3 days | Once daily | 2–3 times per day | | | First thing in the morning |
| Late in daytime | Immediately after meals | | |  | Immediately after dinner |
| Need laxative daily | Other (please specify) | |  |  |  |



|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Bowel nature: | |  |  |  |  |
|  | Soft | | Medium | Hard |  |  |
|  | Bowel movement associated with: | | |  |  |  |
|  | Pain | | Blood | Mucous | Foul smell | |
|  | Other | |  |  |  |  |
|  | Do you delay or suppress any of the following? | | |  |  |  |
|  | Sleep | | Bowel movements | Gas | Urination | Yawning |
|  | Burping | | Thirst | Breathing | Semen | Hunger |
|  | Sneezing | | Tears |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |



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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you travel often? | Yes | No |  |  |
| Do you do self-massage with oil daily? | | | Yes | No |



exercise

How often do you exercise?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Daily |  | Weekly, four times | | Weekly, three times | | Weekly, twice | |
| Weekly, once | | Not at all | |  |  |  |  |
| What type of exercise do you do? | | | |  |  |  |  |
| How long do you exercise each time? | | | |  |  |  |  |
| Rate the intensity of your exercise. | | | | Light | Moderate | | Vigorous |
| eating habits |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Food Groups | Daily |  | Weekly |  | Monthly |  | Never |
| Grains/cereals |  |  |  |  |  |  |  |
| Vegetables |  |  |  |  |  |  |  |
| Fruits |  |  |  |  |  |  |  |
| Dairy |  |  |  |  |  |  |  |
| Eggs |  |  |  |  |  |  |  |
| Poultry |  |  |  |  |  |  |  |
| Meat (beef, pork, etc.) |  |  |  |  |  |  |  |
| Seafood |  |  |  |  |  |  |  |
| Sugar/honey |  |  |  |  |  |  |  |
| Desserts |  |  |  |  |  |  |  |
| Juices |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |



Please describe what you typically eat.

Breakfast



Lunch



 ayurveda intake form

Dinner



Snack



|  |  |  |  |
| --- | --- | --- | --- |
| Do you eat between meals? | Yes | No |  |
| Do you eat your meals at regular times? | Yes | No |  |
| Which is your biggest meal? | Breakfast | Lunch | Dinner |
| Rate your digestion. | Good | Fair | Bad |
| How much water do you drink per day? | None | 1–2 Glasses | 3–4 Glasses |
|  | 5–6 Glasses | 7+ glasses |  |



|  |  |  |  |
| --- | --- | --- | --- |
| Indicate your eating habits. |  |  |  |
| Eat with my full attention on food | | Converse a lot while eating | Eat very quickly |
| Watch television while eating | | Rarely sit down to eat |  |
| Describe your diet. |  |  |  |
| Vegan | Lacto-vegetarian | Lacto-ovo vegetarian |  |
| Other |  |  |  |



If you are a nonvegetarian, please indicate the proteins you eat.

Beef  Pork  Chicken  Turkey  Seafood  Eggs Other



|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Indicate which best describes your sense of taste (if any). | | |  |  |
| Loss of taste |  | Sweet taste in mouth | | Sour taste in mouth |
| Pungent taste in mouth | | Bitter taste in mouth | |  |
| What taste(s) do you like or crave? | |  |  |  |
| Sweet | Salty | Sour | Bitter |  |
| Hot/Spicy | Starches | Oily |  |  |
| Are there particular foods that create discomfort when you eat them? | | | |  |
| Sweet | Salty | Sour | Bitter |  |
| Astringent | Dairy products (including cheese) | |  |  |



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miscellaneous

Do you practice any type of meditation? Please explain.



Do you practice yoga? Please explain.



Which type of weather makes you feel most uncomfortable?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Cold | Hot | Cool and damp | |  |  |  |
| Are you allergic to any substances? | |  |  |  |  |  |
| Food | Pollen |  | Dust |  |  |  |
| Other (please specify) | |  |  |  |  |  |
| Do you smoke cigarettes (or other substances)? | | | Yes |  | No |  |
| If yes, how many per day? | | 1/2 pack | | 1 pack | 2 packs | More than 2 packs |
| How often do you drink alcohol? | |  |  |  |  |  |
| Never |  | Less than once a week | |  | About once a week | |
| Several times a week | | Once a day |  |  | More than once a day | |



|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| How much at a time? | |  |  |  |  |
| How often do you drink caffeinated beverages? | | |  |  |  |
| Never | 1 cup daily | | 2–3 cups daily | 4–5 cups daily |  |
| How would you rate your usual energy level? | | |  |  |  |
| Very high | High | | Moderate | Low | Very low |



Do you experience any of the following?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Depression | | Anxiety | Fear or panic | | Loneliness | Worry |
|  | High stress level | | Anger | Lack of memory | | Light-headedness | |
|  | Lack of energy | | Suicidal thoughts or attempts | | | Irritation |  |
|  | social history | |  |  |  |  |  |
|  | How are your family relationships? | |  | Excellent | Good | Fair | Poor |
|  | How is your social life? | |  | Excellent | Good | Fair | Poor |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |



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|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| How is your mental health? | | Excellent | | Good |  | Fair | Poor |
| How is your career? | | Love it |  | Like it | | It’s bearable | It’s unbearable |
| How purposeful does your life feel? | | |  |  |  |  |  |
|  | Completely | Somewhat | Neutral |  | Purposeless | |  |
| Rate your spiritual life. | |  |  |  |  |  |  |
|  | Fully satisfying | Somewhat satisfying | | | Neutral | Empty |  |
| As a child, did you experience any abuse or trauma? | | | |  | Yes | No |  |
|  | Emotional | Physical | Sexual |  | Verbal | Other (please specify) | |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |



|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| for men only | |  |  |  |  |  |  |  |
| Please indicate which of the following areas are troublesome (if any). | | | | | |  |  |  |
| Hernias | | Sexual difficulty |  | Urination | | Erection problem | | Libido |
| Birth control | | Prostate problems | | Discharge or sores | | | Venereal disease |  |
| Testicular masses | | |  |  |  |  |  |  |
| for women only | |  |  |  |  |  |  |  |
| Age menses began: | |  |  |  |  |  |  |  |
| Which of the following describes your menstruation? | | | |  |  |  |  |  |
| Regular | | Irregular | Too frequent | | Absent |  | Ceased due to menopause | |
| How many days does your menstrual period last? | | | |  |  |  |  |  |
| 1–4 days | | 5–7 days | More than 1 week | | | Irregular throughout the month | | |
| Other |  |  |  |  |  |  |  |  |
| How is your menstrual flow? | |  |  |  |  |  |  |  |
| Normal | | Heavy |  | Light |  | Abnormal vaginal discharge | | |



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|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Do you have any associated symptoms (before or during menstruation)? | | | |  |  |
|  | None | Pain | Fluid retention | Migraine | Depression |
|  | Acne | Tension | Nightmares | Frustration | Loneliness |
| Do you have any discharge outside of your menstrual period? | | | | Yes | No |
| Do you ever experience pain during intercourse? | | | | Yes | No |
| Are you pregnant now? | |  | Yes | No | Don’t know |
| Do you have any sexual difficulties? | | |  | Yes | No |
|  | If yes, please explain. | |  |  |  |



|  |  |  |  |
| --- | --- | --- | --- |
| Do you take contraceptive pills or use other forms of birth control? | | Yes | No |
|  | If yes, please explain. |  |  |



Number of previous pregnancies



Do you have any history of abortion, miscarriage, or problems related to pregnancy or labor? If yes, explain.



How many children do you have?



How old are your children?



|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you do a breast self-exam regularly? | | Yes |  | No |
| Do you experience any of the following? | | Pain or tenderness | Lumps | Nipple discharge |
| Other |  |  |  |  |



other comments (please include anything else you would like us to know)



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I understand that this is an educational Ayurvedic consultation for the purpose of helping me improve my health and wellness. I understand this does not include medical diagnoses or treatment and is not a substi-tute for medical care or an agreement for ongoing care.

Client signature Date



statement of understanding

 I understand that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is an Ayurvedic Consultant and Educator who provides me with infomation on the Ayurvedic approach to health care, which may affect my diet and health in a positive way.

 I understand that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is not a medical doctor or licensed medical practitio-ner, has not presented herself as such, and does not seek to diagnose, treat, or prescribe for disease or other pathological conditions.

 I agree that I am interested in enhancing my own abilities to heal and establish health in mind and body, and this is the reason I have sought Ayurvedic consulting services.

 I agree that I may consult a licensed physician for any concern, at any time, about any disease or pathol-ogy that now exists or arises during my professional relationship with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 Furthermore, I understand that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ encourages regular medical check-ups from a licensed medical professional of my choice, and that any medication that I am now taking upon my licensed physician’s advice, or will take in the future, is taken strictly according to my licensed physician’s directions. Only a licensed physician of my choice can advise on medication dosages or the discontinuance or resumption of such medications.

My signature below acknowledges the above statements as fully read and understood.

Client’s signature Date



Ayurvedic Consultant’s signature Date



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constitution (prakriti) evaluation

Avoid the temptation to evaluate yourself based on how you would like to be rather than how you actually are. If in any category there have been great changes at various times in your life, please select “vata” as your answer even if the vata description in that category does not accurately describe you as you are today.

If in any category you feel that you belong partly in one constitution and partly in another, choose both. If in any category you feel that you fit into all three constitutions, select the two that best characterize you. When-ever you have significant doubt or confusion, select vata. While evaluating yourself keep in mind that

 Vata is cold, dry, mobile, and irregular  Pitta is hot, oily, sharp, and irritable

 Kapha is cold, wet, stable, and soft.

Prakriti evaluation, or body typing, is neither a way to reinforce limitation nor a source of convenient labeling. It is a tool for self-examination and self-development for use in locating and settling into one’s own niche in the cosmos.

|  |  |  |  |
| --- | --- | --- | --- |
| Physical Makeup | Vata | Pitta | Kapha |
|  |  |  |  |
| Body frame | Thin and unusually tall | Medium body | Stout, stocky, or |
| or short | large/broad body |
|  |  |
|  |  |  |  |
| Bones | Light, small bones and/ | Medium bone structure | Heavy/dense bone |
| or prominent joints | structure |
|  |  |
| Body weight | Low | Moderate | Can be overweight |
|  |  |  |  |
| Skin | Dry, rough, cool | Soft, oily, warm | Thick, oily, cool, pale, |
| glistening |
|  |  |  |
|  |  |  |  |
| Hair | Dry, brown, black, coarse, | Soft, fine, often straight, | Thick, oily, lustrous, wavy |
| curly, brittle | oily, early grey, baldness |
|  |  |
| Teeth | Irregular, protruded, | Moderate, yellowish | Regular, strong, white, |
| crooked, thin gums | teeth, soft gums, | healthy |
|  |
| Eyes | Small, brown, black, iris: | Medium, sharp, penetrat- | Big, blue or brown iris, |
| ing, hazel green, light or | thick eyelashes, calm |
| grey, violet, slate blue |
|  | electric blue | eyes |
|  |  |
| Lips | Thin, small, dry | Medium, soft, red | Thick, large, smooth |
| Chin | Thin, angular | Tapering | Rounded, double |
| Neck | Thin, tall | Medium | Big, folded |
|  |  |  |  |
| Fingers | Thin, long, tapering | Medium | Thick, broad, short |
| Endurance | Fair | Good | High |
| Score |  |  |  |
|  |  |  |  |



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|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | Physical Functions | | Vata | Pitta | Kapha |  |
|  |  |  | |  |  |  |  |
|  |  | Appetite | | Variable, scanty | Good, excessive | Steady, constant |  |
|  |  |  | |  |  |  |  |
|  |  | Thirst | | Variable | Excessive | Less |  |
|  |  |  |  |  |  |  |  |
|  |  | Sweat/body odor | | Low, scanty, no smell | Profuse, hot, | Moderate, cool, |  |
|  |  |  | strong smell | pleasant smell |  |
|  |  |  |  |  |  |
|  |  | Sleep | | Light, interrupted | Moderate, 6–8 hrs | More than 8 hrs |  |
|  |  |  | |  |  |  |  |
|  |  | Speech | | Talkative, may ramble | Speaks purposefully | Speaks less cautiously |  |
|  |  |  |  |  |  |  |  |
|  |  | Elimination | | Irregular, dry, hard, | Regular, soft, sometimes | Regular, solid, well |  |
|  |  | tendency toward gas | loose | formed |  |
|  |  |  |  | and constipation |  |  |  |
|  |  | Physical activity | | Fast and very active | Medium | Slow and steady |  |
|  |  |  | |  |  |  |  |
|  |  | Sexual activity | | Lower, variable | Moderate | Good |  |
|  |  |  | |  |  |  |  |
|  |  | Weight | | Hard to gain, easy to lose | Easy to gain, easy to lose | Easy to gain, hard to lose |  |
|  |  | Climate preference | | Prefers warm | Prefers cool | Enjoys changes of |  |
|  |  |  |  | seasons |  |
|  |  |  |  |  |  |  |
|  |  | Taste preference | | Prefers sweet, sour, salty | Prefers sweet, bitter, or | Prefers pungent, bitter, or |  |
|  |  |  | astringent | astringent foods |  |
|  |  |  |  |  |  |
|  |  | Sensitivities | | Cold, dryness, wind | Heat, sunlight, fire | Cold, damp |  |
|  |  | Score | |  |  |  |  |
|  |  |  | |  |  |  |  |
|  |  |  | |  |  |  | |
|  |  | Psychological | | Vata | Pitta | Kapha |  |
|  |  |  | |  |  |  |  |
|  |  | Mind | | Restless, always active | Aggressive, intelligent | Calm |  |
|  |  |  |  |  |  |  |  |
|  |  | Dreams | | Fearful flying, jumping, | Fiery, passionate, anger, | Watery, rivers, oceans, |  |
|  |  | running | violence | swimming, romantic |  |
|  |  |  |  |  |
|  |  | Temperament | | Nervous, changeable | Motivated, aggressive | Calm, content, |  |
|  |  |  |  | conservative |  |
|  |  |  |  |  |  |  |
|  |  | Faith | | Changeable | Determined fanatic | Steady, slow to change |  |
|  |  |  |  |  |  |  |  |
|  |  | Memory | | Easily notices things but | Sharp | Slow to take notice but |  |
|  |  | easily forgets |  | won’t forget |  |
|  |  |  |  |  |  |
|  |  | Interest/habits | | Dancing, artistic | Competitive ventures, | Family and social |  |
|  |  | activities, talking | debate, politics, hunting | gatherings, cooking, |  |
|  |  |  |  |  |  | collecting |  |
|  |  | Positive emotions | | Adaptability | Courage | Love |  |
|  |  |  |  |  |  |  |  |
|  |  | Negative emotions | | Feels fear often | Often afflicted with | Attachment |  |
|  |  |  | anger |  |  |
|  |  |  |  |  |  |  |
|  |  | Finances | | Spends on trifles | Spends money on | Good money preserver |  |
|  |  |  | luxuries |  |  |
|  |  |  |  |  |  |  |
|  |  | Moods | | Changes quickly | Changes slowly | Steady, non-changing |  |
|  |  |  | |  |  |  |  |
|  |  | Memory | | Short-term is best | Good general memory | Long-term is good |  |
|  |  |  | |  |  |  |  |
|  |  | Score | |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

