



# Ayurvedic Healing

2541 Soquel Ave, Santa Cruz, CA 95062 phone 831.462.3776 fax 831.462.3706 [www.ayurvedichealing.net](http://www.ayurvedichealing.net)

## Confidential Client History

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone - Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ Birth Date : \_\_\_\_\_ Birth Time: \_\_\_\_\_

Birth Place (City, State, Country): \_\_\_\_\_ 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

Credit Card # \_\_\_\_\_ Exp. Date: \_\_\_\_\_ 3-Digit Code: \_\_\_\_\_

Visa  Mastercard  American Express  Discover

## 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 o \_\_\_\_\_

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 <input type="checkbox"/> yes <input type="checkbox"/> no     | Heart surgery <input type="checkbox"/> yes <input type="checkbox"/> no                     |
| Anemia <input type="checkbox"/> yes <input type="checkbox"/> no                          | Hepatitis A <input type="checkbox"/> yes <input type="checkbox"/> no                       |
| Arthritis <input type="checkbox"/> yes <input type="checkbox"/> no                       | Hepatitis B <input type="checkbox"/> yes <input type="checkbox"/> no                       |
| Asthma, Pneumonia, TB <input type="checkbox"/> yes <input type="checkbox"/> no           | Hepatitis Non-A/Non B <input type="checkbox"/> yes <input type="checkbox"/> no             |
| Blood Pressure, high/low <input type="checkbox"/> yes <input type="checkbox"/> no        | HIV Exposure <input type="checkbox"/> yes <input type="checkbox"/> no                      |
| Cancer <input type="checkbox"/> yes <input type="checkbox"/> no                          | Frequent attacks of colds /coughs <input type="checkbox"/> yes <input type="checkbox"/> no |
| Chronic Constipation <input type="checkbox"/> yes <input type="checkbox"/> no            | Chronic Diarrhea <input type="checkbox"/> yes <input type="checkbox"/> no                  |
| Chemotherapy/ Radiation <input type="checkbox"/> yes <input type="checkbox"/> no         | Kidney or Bladder disease <input type="checkbox"/> yes <input type="checkbox"/> no         |
| Chest Pain <input type="checkbox"/> yes <input type="checkbox"/> no                      | Mental Disorder <input type="checkbox"/> yes <input type="checkbox"/> no                   |
| Cholesterol, elevated <input type="checkbox"/> yes <input type="checkbox"/> no           | Jaundice, Gallstone <input type="checkbox"/> yes <input type="checkbox"/> no               |
| Dental complications <input type="checkbox"/> yes <input type="checkbox"/> no            | Ear pain or ringing <input type="checkbox"/> yes <input type="checkbox"/> no               |
| Diabetes <input type="checkbox"/> yes <input type="checkbox"/> no                        | Jaw pops, clicks or locks <input type="checkbox"/> yes <input type="checkbox"/> no         |
| Dizziness <input type="checkbox"/> yes <input type="checkbox"/> no                       | Prolonged bleeding when cut <input type="checkbox"/> yes <input type="checkbox"/> no       |
| Epilepsy, convulsions, seizures <input type="checkbox"/> yes <input type="checkbox"/> no | Rheumatic Fever <input type="checkbox"/> yes <input type="checkbox"/> no                   |
| Fainting <input type="checkbox"/> yes <input type="checkbox"/> no                        | Sinusitis <input type="checkbox"/> yes <input type="checkbox"/> no                         |
| Feet or ankle swelling <input type="checkbox"/> yes <input type="checkbox"/> no          | Shortness of Breath <input type="checkbox"/> yes <input type="checkbox"/> no               |
| Glaucoma, eye surgery <input type="checkbox"/> yes <input type="checkbox"/> no           | Stroke <input type="checkbox"/> yes <input type="checkbox"/> no                            |
| Heart Attack <input type="checkbox"/> yes <input type="checkbox"/> no                    | Thyroid disease <input type="checkbox"/> yes <input type="checkbox"/> no                   |
| Heart disease/ Heart murmur <input type="checkbox"/> yes <input type="checkbox"/> no     | Ulcers, Intestinal bleeding <input type="checkbox"/> yes <input type="checkbox"/> no       |
| Implant/Prosthesis <input type="checkbox"/> yes <input type="checkbox"/> no              | Venereal Diseases <input type="checkbox"/> yes <input type="checkbox"/> 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: \_\_\_\_\_