

Ayurveda New Client Health History Form

CONTACT INFORMATION:

Client Name _____ Date _____
Home Address _____
Daytime Phone _____ Evening Phone _____ Cell Phone _____
E-mail _____

PERSONAL INFORMATION:

DOB _____ Time of Birth _____ Place of Birth: City _____ State/Region _____ Country _____
Age _____ Occupation: _____ Marital Status _____ Children & Ages: _____
Referred by _____ Family Physician _____
Primary Care Provider Name & Title _____ Phone _____
Address _____

OBJECTIVES:

Please check the items that reflect your main objectives:

Please note that **Ayurvedic Consultations do not include medical diagnosis and treatments**. If you are concerned about a medical condition or a latent or potential medical condition you should see a medical doctor.

- ☐ 1. I would like an alternative approach to allopathic medicine for managing illness and disease ()
☐ 2. I would like to improve my general health and wellness and reduce my vulnerability to illness and disease
☐ 3. I would like to improve my lifestyle and dietary practices to improve my health
☐ 4. I would like to change my habits and behavioral patterns to improve my relationships with others
☐ 5. I would like to manage stress, tension and worry to attain a more stable emotional nature

How would your life be different if you were to achieve these objectives to your satisfaction? _____

Are you currently under a physician's care for a specific medical problem? (If yes, for what) _____

CONCERNS: Please tell us your present concerns. How long have they troubled you? _____

GOALS: What would you like to achieve or change in terms of your health and wellness? _____

Last physical examination: Date _____ Blood Pressure _____ Cholesterol _____ BLOOD TYPE _____

Height _____ Weight _____ Weight Changes _____

What prescription drugs or medications are you currently taking? (how often, how much, how many years)

Prescription:	Reason	Duration taken	Current dosage	Quantity per	Frequency per day	Before/after/during or between meals

Herbal/ vitamin supplements	Reason	Duration taken	Current dosage	Quantity per	Frequency per day	Before/after/during or between meals

History of Smoking: _____ Alcohol: _____ Caffeine _____ Recreational / Non-prescription Drugs: _____



What surgeries/major accidents/major traumas have you had? (Include dates) _____

C) PERSONAL HISTORY:

Do you or your family members have a history of: (check the boxes that apply)

	Myself	Family	Member		Myself	Family	Member
		Maternal	Paternal			Maternal	Paternal
Allergies to Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cerebro Vascular Accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Treatment Complications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain in the Ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Non-A / Non-B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in the Ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gallstone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurring Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feet or Ankles Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Implant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding When Cut	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Diseases (STDs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV Exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

History of Any Other Disease Or Problems? (Please list any other allergies, illnesses, surgeries, diseases, injuries, trauma, emotional stresses, mental stresses, life-style conditions, addictions, alcohol, drug abuse, changes of weight, or anything else to help us clearly understand your health condition)



FAMILY HISTORY: Any other family illnesses? _____

EXERCISE: Do you currently engage in any exercise or physical activity? ____ If so, what type(s)? _____

Have you ever done Yoga postures before? _____ If so, what type(s), how often? _ _____

COMMUNITY: Do you have any weekly meetings, activities with friends, neighbors, teams? ____ If so, what type(s)? _____

EMOTIONAL HEALTH: Are you content with your education on emotional health, communication and relationships? _____
Do you have resources for processing challenges in your life currently?

SPIRITUALITY: Do you have a weekly church, temple or similar that you attend? _____

What is your philosophy on why you are here and what happens when you die?

FEMALES: Age of onset of menses _____ Are you pregnant? _____ Number of Months _____ Number of previous pregnancies ____
Difficult past pregnancies _____ Complications _____

Birth Control ☐ yes ☐ no What Type(s) _____ How long and history of use _____

Date of Last Menstrual Period _____ Length of cycle _____

Cycles: ☐ regular ☐ irregular _____ Days between cycles _____ Flow: ☐ heavy, ☐ med, ☐ light Color of blood ____

Clots: ☐ yes ☐ no When _____ Pain and/or difficulty during cycle _____

PMS symptoms: _____

Any other symptoms during cycle: _____

Yeast infections: _____

Urinary tract infection (UTI) (frequency, duration): _____

Menopausal stage / symptoms: _____

Over 45, date of last breast exam: _____

Over 45, date of last colon exam: _____

MALES: Prostate Condition _____

Any sexual debility? _____

If yes, what treatments have you tried? _____

Over 45, date of last colon exam: _____



Check all that apply:

Category	V	P	K
Digestion	<input type="checkbox"/> Irregular with <input type="checkbox"/> Bloating <input type="checkbox"/> Gas/Flatulence <input type="checkbox"/> Abdominal Discomfort <input type="checkbox"/> Gurgling Intestines <input type="checkbox"/> Breathlessness	<input type="checkbox"/> Quick digestion with <input type="checkbox"/> Acid Indigestion <input type="checkbox"/> Heartburn <input type="checkbox"/> Burning pain <input type="checkbox"/> Still hungry after eating <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting	<input type="checkbox"/> Slow digestion with <input type="checkbox"/> Feeling of heaviness <input type="checkbox"/> Lethargy <input type="checkbox"/> Sleepy after eating <input type="checkbox"/> Low energy after meals <input type="checkbox"/> Excess mucous secretions
Appetite	<input type="checkbox"/> Irregular <input type="checkbox"/> Sometimes eats at midnight	<input type="checkbox"/> Excess hunger <input type="checkbox"/> Sharp hunger <input type="checkbox"/> Desire to eat large amount of food <input type="checkbox"/> Strong unbearable appetite <input type="checkbox"/> Feels hypoglycemic	<input type="checkbox"/> Emotional eating (No urge for food but still the person eats) <input type="checkbox"/> Dull / No appetite
Cravings	<input type="checkbox"/> Fried food <input type="checkbox"/> Hot spicy food <input type="checkbox"/> Meat or other protein	<input type="checkbox"/> Sweets <input type="checkbox"/> Cooling foods & drinks	<input type="checkbox"/> Hot, sharp, dry & spicy food <input type="checkbox"/> Wine or alcohol
Elimination	<input type="checkbox"/> Tendency toward constipation <input type="checkbox"/> Dry <input type="checkbox"/> Irregular <input type="checkbox"/> Defecates without satisfaction <input type="checkbox"/> Passes gas during elimination	<input type="checkbox"/> Loose stools <input type="checkbox"/> Diarrhea	<input type="checkbox"/> Mucous in stool
Pain (where, when, how often)	<input type="checkbox"/> Shifting <input type="checkbox"/> Moving <input type="checkbox"/> Vague <input type="checkbox"/> Throbbing <input type="checkbox"/> Cutting <input type="checkbox"/> Excruciating with breathlessness, fear and tachycardia	<input type="checkbox"/> Burning <input type="checkbox"/> Sharp <input type="checkbox"/> Hot <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Sucking pain with fever, nausea and irritability <input type="checkbox"/> Intense pain	<input type="checkbox"/> Dull <input type="checkbox"/> Stable <input type="checkbox"/> Deep dull aching pain <input type="checkbox"/> Can sleep through the pain
Skin	<input type="checkbox"/> Dry <input type="checkbox"/> Cracked <input type="checkbox"/> Rough <input type="checkbox"/> Thin <input type="checkbox"/> Discolored <input type="checkbox"/> Patchy	<input type="checkbox"/> Hives <input type="checkbox"/> Rash <input type="checkbox"/> Urticaria <input type="checkbox"/> Acne <input type="checkbox"/> Tender <input type="checkbox"/> Warm/hot to touch <input type="checkbox"/> Redness <input type="checkbox"/> Boils <input type="checkbox"/> Ruddy <input type="checkbox"/> Itchy	<input type="checkbox"/> Excess oily <input type="checkbox"/> Thick <input type="checkbox"/> Pallor <input type="checkbox"/> Cold/clammy <input type="checkbox"/> Lustrous
Sleep	<input type="checkbox"/> Insomnia <input type="checkbox"/> Need night light <input type="checkbox"/> Restless <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> Fearful, lonely awake	<input type="checkbox"/> Interrupted sleep <input type="checkbox"/> Must have complete darkness <input type="checkbox"/> Needs to read/TV to sleep <input type="checkbox"/> Thinking, processing, need to be in control - awake	<input type="checkbox"/> Excess sleep <input type="checkbox"/> Daytime napping <input type="checkbox"/> Heavy sleeper <input type="checkbox"/> Slow to awaken <input type="checkbox"/> Hypersomnia
Seasonal Allergies	<input type="checkbox"/> Breathlessness <input type="checkbox"/> Wheezing <input type="checkbox"/> Constricted Breathing	<input type="checkbox"/> Rash <input type="checkbox"/> Itching eyes <input type="checkbox"/> Hives <input type="checkbox"/> Irritation <input type="checkbox"/> Inflammation	<input type="checkbox"/> Runny nose <input type="checkbox"/> Watery eyes <input type="checkbox"/> Congestion
Food Sensitivity	<input type="checkbox"/> Night shades <input type="checkbox"/> Left-overs <input type="checkbox"/> Dry fruits <input type="checkbox"/> Raw food	<input type="checkbox"/> Hot spicy foods <input type="checkbox"/> Sour foods <input type="checkbox"/> Fermented foods	<input type="checkbox"/> Dairy products
Sweating	<input type="checkbox"/> Scanty or no sweat	<input type="checkbox"/> Excess <input type="checkbox"/> Profuse with body odor	<input type="checkbox"/> Cold/clammy
Muscle Reactivity	<input type="checkbox"/> Twitching <input type="checkbox"/> Cramping <input type="checkbox"/> Weakness <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Spasms	<input type="checkbox"/> Bruising <input type="checkbox"/> Tenderness to touch <input type="checkbox"/> Sore <input type="checkbox"/> Excess heat	<input type="checkbox"/> Tumors <input type="checkbox"/> Cysts <input type="checkbox"/> Growths <input type="checkbox"/> Generalized weakness



Category	V	P	K
Bone and Joints	<input type="checkbox"/> Painful <input type="checkbox"/> Popping <input type="checkbox"/> Cracking <input type="checkbox"/> Stiffness <input type="checkbox"/> Loose <input type="checkbox"/> Osteopenia <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Medical fractures <input type="checkbox"/> Scoliosis	<input type="checkbox"/> Inflamed <input type="checkbox"/> Hot / feverish <input type="checkbox"/> Tender <input type="checkbox"/> Inflammatory arthritis <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Bursitis <input type="checkbox"/> Psoriasis	<input type="checkbox"/> Swollen joints <input type="checkbox"/> Bone tumors <input type="checkbox"/> Bone spurs <input type="checkbox"/> Osteosarcoma <input type="checkbox"/> Bone spurs <input type="checkbox"/> Sclerosis
Circulation	<input type="checkbox"/> Cold extremities (hands, feet)	<input type="checkbox"/> Burning hands / feet <input type="checkbox"/> Bruises easily <input type="checkbox"/> Tendency toward bleeding	<input type="checkbox"/> Cold clammy hands <input type="checkbox"/> Varicose veins <input type="checkbox"/> Thrombotic element
Body weight	<input type="checkbox"/> Variable <input type="checkbox"/> Can't gain weight <input type="checkbox"/> Thin or slender	<input type="checkbox"/> Stable <input type="checkbox"/> Tendency toward hyper metabolism	<input type="checkbox"/> Tendency to easily gain weight <input type="checkbox"/> Over-weight <input type="checkbox"/> Obese <input type="checkbox"/> Voluptuous <input type="checkbox"/> Stout
General Symptomatology	<input type="checkbox"/> Dry cough <input type="checkbox"/> Ringing ears <input type="checkbox"/> Light-headed <input type="checkbox"/> Dryness: external/internal <input type="checkbox"/> Hemorrhoids: external / non-bleeding <input type="checkbox"/> Low back ache <input type="checkbox"/> Irregular metabolism <input type="checkbox"/> Dry mouth <input type="checkbox"/> Receding gums <input type="checkbox"/> Blackish brownish discoloration <input type="checkbox"/> Fatigue <input type="checkbox"/> Lack of power, tone & strength <input type="checkbox"/> Paralysis <input type="checkbox"/> Slipped disc <input type="checkbox"/> Hernia <input type="checkbox"/> Difficulty sweating <input type="checkbox"/> Cold extremities (hands, feet)	<input type="checkbox"/> Spontaneous bleeding <input type="checkbox"/> Hyper-sensitive to smells <input type="checkbox"/> Hair loss <input type="checkbox"/> Excess thirst <input type="checkbox"/> Hemorrhoids: internal / bleeding <input type="checkbox"/> Hot flashes <input type="checkbox"/> Tendency toward inflammatory conditions <input type="checkbox"/> Acidic saliva <input type="checkbox"/> Hyper acidity <input type="checkbox"/> Yellowish discoloration <input type="checkbox"/> Fainting <input type="checkbox"/> High metabolism <input type="checkbox"/> Auto-Immune Disorder	<input type="checkbox"/> Cold <input type="checkbox"/> Cough <input type="checkbox"/> Congestion <input type="checkbox"/> Excess urination <input type="checkbox"/> Frequent urination <input type="checkbox"/> Fibrocystic <input type="checkbox"/> Over salivation <input type="checkbox"/> Edema <input type="checkbox"/> Slow metabolism <input type="checkbox"/> Albuminuria <input type="checkbox"/> Lipoma(s) <input type="checkbox"/> Cataracts
Mental-Emotional	<input type="checkbox"/> Transient Depression <input type="checkbox"/> Inability to concentrate <input type="checkbox"/> Forgetful <input type="checkbox"/> Worry <input type="checkbox"/> Fear <input type="checkbox"/> Anxiety <input type="checkbox"/> Insecurity <input type="checkbox"/> Loneliness <input type="checkbox"/> Nervousness <input type="checkbox"/> Grief <input type="checkbox"/> Restlessness <input type="checkbox"/> Repetitive thinking <input type="checkbox"/> Spacey	<input type="checkbox"/> Extreme depression with suicidal tendencies <input type="checkbox"/> Anger <input type="checkbox"/> Rage <input type="checkbox"/> Resentful <input type="checkbox"/> Judgmental <input type="checkbox"/> Critical <input type="checkbox"/> Envious <input type="checkbox"/> Sharp tongued <input type="checkbox"/> Vengeful <input type="checkbox"/> Intolerant <input type="checkbox"/> Irritable <input type="checkbox"/> Aggressive <input type="checkbox"/> Success-Failure mind set <input type="checkbox"/> Seeks power, prestige and position	<input type="checkbox"/> Prolonged depression <input type="checkbox"/> Sloppy <input type="checkbox"/> Slow <input type="checkbox"/> Confused <input type="checkbox"/> Greed <input type="checkbox"/> Attachment <input type="checkbox"/> Mental lethargy <input type="checkbox"/> Resistant to change <input type="checkbox"/> Laziness <input type="checkbox"/> Unforgiving <input type="checkbox"/> Stubborn <input type="checkbox"/> Boredom
Nature of response within relationships	<input type="checkbox"/> Talkative <input type="checkbox"/> Uncertain <input type="checkbox"/> Anxious <input type="checkbox"/> Lonely <input type="checkbox"/> Insecure <input type="checkbox"/> Excitable <input type="checkbox"/> Shy <input type="checkbox"/> Spacey	<input type="checkbox"/> Seeks power, prestige and position <input type="checkbox"/> Perfectionist <input type="checkbox"/> Competitive <input type="checkbox"/> Seeker of knowledge	<input type="checkbox"/> Based on acquiring comfort & pleasure

I understand that my health history form will be kept private, unless I authorize it's shared use with another health care provider or entity.

I understand that I am an equal with my health care provider. I will speak up for myself if I am feeling uncomfortable with any questioning, procedure or suggested plan of action. I will co-create a realistic, gardening plan of action.

I recognize that I am the main gardener of my health and in asking for help I am taking a positive step toward change. Signed _____ Date _____

