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AYURVEDA INTAKE

Name: ____

Street: ____________________ City, State ____________________ Zip: __________

Home Phone: ____________________ Cell Phone: ____________________

E-Mail Address (for appointment confirmations & Monthly newsletter) ____________________

Date of Birth: __________ Occupation: __________ Employer: __________

Age: __________ Height: __________ Approx. blood pressure? __________ With Meds? ______

By whom were you referred? ____________________

What is your chief complaint or reason(s) for this visit? ____________________

When did this become a concern or challenge? ____________________

____

What was happening in your life at the time?

____

____

What is happening now? ____________________

____

What are your personal health or life goals, dreams, interest?

Past ? ____________________ ____________________

Present ? ____________________

____

What would you personally like to receive now concerning these issues?

____

____

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HEALTH AND LIFESTYLE HISTORY

Serious illnesses? ____

Hospitalizations?____

List any other pertinent conditions____

Have you been under the care of any licensed health care professional in the last year?

YES NO

If so, for what reasons?

____ ______

Have you had any cosmetic surgery or procedures performed?

YES NO

If so, please list the dates

____

IMMEDIATE FAMILY HISTORY

Please indicate these conditions: Heart Disease, Stroke, High Blood Pressure, Cancer, Diabetes, Etc.

Grandmother____

Mother____

Grandfather____

Father____

Brother____

Sister ____

Do you or any of your family members suffer from any kind of addiction?

Including Food, beverages, recreational drugs, tobacco, and alcohol.

____

____

Are you taking any medication, herbs, or vitamins?____

____

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HEALTH/LIFESTYLE HISTORY CONTINUED

Do you have any allergies or sensitivities to food, pollen, medicines, etc..?____

____

What does spirit mean to you?

____

Is your life spiritual?____

Is your life purposeful?____

Do you have personal friends and relationships?____

Are you personal friends and relationships loving, satisfying, and supportive?____

What is your profession and was it satisfying?____

Do you have any personal or professional goals? Name a few.____

Do you have any hobbies?____

Do you spend time outdoors?____

Do you notice dominant or habitual thoughts, feelings, sensations, or images?____

Please indicate the frequency or intensity of your emotional patterns, such as the frequency that they occur, the intensity, and where they happen.

Anxiety/Worry____

Overwhelm____

Self-Destructiveness____

Anger/Frustration____

Resentment____

Critical/Blaming____

Intense____

Lethargic____

Sadness/Melancholy____

Depression____

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Please indicate the frequency or intensity of pain or discomfort in your physical body.

Please indicate frequency and intensity of your healthy patterns____
Joy/Happiness____
Enthusiasm/Optimism____
Courage/Confidence____
Self-Love/Self Acceptance____
Peace/Calm____
Creativity/Prosperity____

What is your typical daily schedule? Please include details such as wake, sleep, rise, work, exercise, and play.____
____
____
____

Please list examples of typical daily meals, food and beverage choices and cravings.

Breakfast____
Lunch____
Dinner____
Snacks____
Health food____
Junk food____

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Tell me more about the 3 Pillars of health and the quality of each of the following:

Digestion

- ☐ Gas
- ☐ Belching
- ☐ Acid Reflux
- ☐ Burning
- ☐ Indigestion
- ☐ Nausea or Vomiting
- ☐ Sleepy after Eating
- ☐ Heaviness after Eating
- ☐ Bloated after Eating
- ☐ Other

Elimination

- ☐ Constipation
- ☐ Alternating Constipation and Diarrhea
- ☐ Blood in Stool
- ☐ Rectal Pain or Hemorrhoids
- ☐ Mucus in Stool
- ☐ Abdominal Pain
- ☐ Other

Sleep

- ☐ Insomnia
- ☐ Wake Periodically
- ☐ Light Sleep
- ☐ Sound Sleep
- ☐ Heavy Sleep
- ☐ Rise Refreshed
- ☐ Rise Tired
- ☐ Other

3. ENERGY:

- ☐ Sexual Energy
- ☐ Energy in Personal Relationships
- ☐ Energy in Professional Relationships
- ☐ Daily Energy

Any questions concerns or comments?____

____

____

____

____

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Diet, Nutrition & Lifestyle Consultation
Body / Mind Constitution Assessment

*Check the most dominant or typical description

Face	☐ Oblong	☐ Angular	☐ Round
Forehead	☐ Small	☐ Medium	☐ Large
Eyes	☐ Black/Brown Small/Unsteady	☐ Hazel/Green/Gray Deep Set/Piercing/Reddish	☐ Blue/Brown Large/White/Wide
Nose Bridge	☐ Narrow/ Small	☐ Medium	☐ Large/Wide
Lips	☐ Thin/Dry	☐ Medium/Soft	☐ Large/Smooth
Teeth	☐ Large/Protruding Crooked	☐ Moderate Yellowish	☐ Large/White Little Decay
Tongue	☐ Thin/Grayish	☐ Moderate/Yellowish	☐ Thick/Whitish
Chin	☐ Thin/Oblong/Angular	☐ Angular/Tapered/Square	☐ Square/Round/Double
Neck	☐ Long/Thin	☐ Medium	☐ Thick/Short/Wide/Folds
Chest	☐ Flat/Sunken	☐ Moderate	☐ Round/Expanded
Skin	☐ Dry/Cool Dark Lacks Tone/Lustre Chapping/Cracking Dry Eczema/Rough Patches Corns/Callouses General Dryness	☐ Oily T-Zone/Soft Fair/Sensitive Freckles/Pink/Red Rashes/ Inflammation/Itching Blackheads Yellow Pustular Acne General Excessive Oiliness	☐ Oily/Thick Oily/Moist Pale/White Dull/Sluggish Enlarged Pores Blackheads Large Pustules/Cystic Forms Thick Oily Secretions
Skin Aged	☐ Dry/Flaky/Wrinkles	☐ Premature Wrinkles Redder/Freckles/Moles	☐ Smooth/Fewer Wrinkles
Skin/Scalp	☐ Dandruff/Dry Scalp	☐ Pigment Discoloration	☐ Oily Scalp
Hair Color	☐ Dark Brown/Black	☐ Light Brown/Blond/Red Early Gray	☐ Medium Blond/Medium Brown to Dark Brown

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Hair Texture	Dry/Curly/Kinky Dull/Frizzy Split Ends/Scaliness Bald Spots	Soft/Oily/Fine Wavy/Straight Thinning/HairLoss Male Pattern Baldness	Oily/Thick Wavy/Straight Glossy/Shiney Grows Easily
Nails	Thin/Cracking	Medium/Pink/Soft	Thick/White
Bones	Small/Narrow/Long	Moderate/Average	Large/Thick/ Short/Wide
Body Frame	Small/ Ectomorph Narrow Hips/Shoulders	Medium/Mesomorph	Large/Endomorph Broad Hips/Shoulders
Body Weight	Thin/Bony/Flexible Hard to Gain	Medium/Muscular/Athletic Stays Constant	Heavy/Thick/Solid Easy to Gain
Voice	High or Low Pitch/Weak	High Pitch/Sharp	Low Pitch/Deep/Tonal
Speech	Fast/Talkative/Excessive Vibrato/Dissonant/Weeping	Clear/Moderate/Detailed Laughing/Arguable	Slow/Melodious/Monotone Silent
Taste	Sweet/Sour/Salty	Sweet/Bitter/Astringent	Spicy/Bitter/Astringent
Cravings	Oily/Heavy/Sweet/Salty Cooked Foods/Hot Drinks	Medium/Light/Sweet Cold Foods & Drinks	Dry/Light/Sweet/Crunchy Spicy Food & Drink
Appetite	Erratic/Variable Excessive to No Interest	Strong/Intense Needs Regular Meals	Low/Constant/Emotional Skips Meals
Digestion	Eat Fast Upset Stomach Gas/Bloating	Eat Anything Smelly/Gas Burning Indigestion	Eat Slow Heavy Stomach Sluggish Digestion
Elimination	Irregular Dry/Hard/Small/Gas Constipation	Twice or More Daily Soft/Oily/Loose/Hot Diarrhea	Regular Daily Heavy/Slow/Thick/Formed White Mucous
Menses	Scanty/Irregular	Intense Flow Light Clotting	Long Flow Heavy Clotting

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Body / Mind Constitution Assessment

Perspiration	☐ Not Easily	☐ Easily	☐ Very Little
Climate	☐ Dislike Cold Prefer Warm/Hot Cold Hands & Feet	☐ Dislike Heat Prefer Cool/Cold Warm Hands	☐ Dislike Damp Cold Tolerates Extremes Cool Hands
Sensitivity	☐ Loud Sounds	☐ Bright Light	☐ Strong Smells
Energy	☐ High Worn Out Easily	☐ Medium/High Over-Works	☐ Medium/Low Steady Stamina
Activity	☐ Active/Quick Fast Moving/Restless	☐ Intense/Focused Competitive/Multi-Task	☐ Slow/Regular Methodical/Leisurely
Mind	☐ Quick/Restless Questions/Theorizes Short Attention Indecisive	☐ Sharp/Penetrating Critical/Artistic Detail Oriented Decisive	☐ Stable/Slow Lethargic/Logical Big Picture Stubborn
Learning	☐ Listening	☐ Seeing/Reading	☐ Association/Memory
Memory	☐ Short Term Best Forgets Quickly	☐ Good/Clear Not Prolonged	☐ Long Term Best Never Forget
Behavior	☐ Changing/Radical Little Follow Through	☐ Goal Oriented/Leader Organized/Follow Through	☐ Constant/Loyal Slow Start/Follow Through
Moods	☐ Change Quickly	☐ Change Slowly	☐ Mostly Steady
Emotion	☐ Creative Enthusiastic/Vivacious	☐ Fiery Desire/Determination	☐ Calm Nurturing/Affectionate
Stress	☐ Anxiety Insecure/Worry	☐ Anger Aggressive/Irritable	☐ Depression Lazy /Melancholy
Temperament	☐ Imaginative Adaptable/Accepting Free Spirited	☐ Intelligent Authoritative/Courageous Efficient/Perfectionist	☐ Caring Agreeable/ Easy Going Indifferent

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Diet, Nutrition & Lifestyle Consultation
Body / Mind Constitution Assessment

Reactions	☐ Excitable Dramatic Unpredictable Impulsive Nervous/Fearful	☐ Quick Tempered Controlling Overwhelm Impatient Critical/Judgmental	☐ Even Tempered Sentimental Withdraws Patient Stuck/Stubborn
Interests	☐ Travel/Nature	☐ Sports/Politics	☐ Water/Flowers
Money	☐ Spends Quickly Impulsive/Excessive	☐ Spends/Saves Impulsive/Deliberate	☐ Saves/Accumulates
Relationships	☐ Friendly/Sociable Variety/Changing	☐ Value Centered Colleagues/Co-Workers	☐ Gradual/Friendly Sincere/Lasting
Sexual Desire	☐ Low/Moderate	☐ Moderate/Strong	☐ Gradual/Cyclic/Strong
Sleep	☐ Light/Interrupted Worry Insomnia	☐ Moderate/Sound Problem Solving Insomnia	☐ Deep/Long/Sound Awaken Slowly
Dreams	☐ Flying/Looking Down Running/Chase/Anxious Difficult Remembering	☐ Fighting/Violence/Strife Color/Fire/Angry Easy Remembering	☐ Romantic/Water Ocean/Clouds Remember Intense
Pulse Beats	**80-100**	**70-80**	**60-70**
TOTAL	**VATA**	**PITTA**	**KAPHA**