Healthy-You Ayurveda

Empowering Individuals to nourish both
mind and body for long-term health

Health Seeker Intake form

Today's Date: 07/17/2024		Age:	Gender: ❑ F ❑ M
Name (Last, First, MI):		Height:	Weight:
Address (No. Street):		**Date of Birth:**	Place of Birth
City, State, Zip Code:		**Phone** C h w	
E-mail:	**Occupation:**	❑ Married ❑ Single	❑ Divorced/Separated ❑ Cohabitating ❑ Widowed
Emergency Contact Name: **Phone:**		**Referred by:**	

What is your ethnicity?

Native American	Asian	Hispanic	Mediterranean
African American	South Asian	Caucasian	Northern European
Other			

With whom do you live? *Include children, parents, other occupants, and pets with ages*

What do you hope to achieve with your health consultation today?

Main problem(s) you would like help with

Describe problem	Start date	Mild/Moderate/Severe	Attempted treatment and response

Mild – some discomfort, Moderate – creates much trouble, but can continue regular activities, severe – restricts your daily routine

Are you diagnosed with any medical conditions?

Conditions	Start date	Control status	Treating physician, affiliation

Are you taking any prescription medications?

Medication Name	Start date	Dosage	Prescribed by

Are you taking any herbal or alternative medicine?

Name	Start date	Dosage	Prescribed by

Are you taking any vitamins or nutritional supplements?

Name with dose of main ingredients	Start date	Regularity	Given by

e.g., One a Day, Centrum, other vitamins

Family History *Fill only the positive yes as 'Y' or a tick mark*

	Father	Mother	Brother(s)	Sister(s)	PGM	PGF	MGM	MGF
Diabetes								
Hypertension								
Heart Disease								
Stroke								
Asthma								
Cancer (type)								
Hypothyroid								
Arthritis								
Other								
If not living, age of and cause of death								

PGM, PGF = Paternal grandmother, grandfather; MGM, MGF =maternal grandmother, grandfather

Were there any diseases that you suffered from earlier?

Disease	Start and end date	Treatment – drugs, exercise, etc.

Include major infections like typhoid, malaria, hepatitis

Have you had any kind of surgery or minor procedures performed on you?

Procedure	Date	Who and where was it performed

Include any Panchakarma, Acupuncture and other treatments here as well

Please list any hospitalizations

Year	Condition	Procedure done

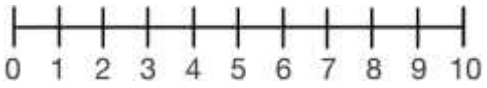
How much do you physically move your body?

Activity	Intensity	Hours	Days/ week	Start date
How often do you break a sweat with exercise? (times/week)				
How many hours do you watch TV every week?				
Do you watch TV, read or surf while eating meals?				

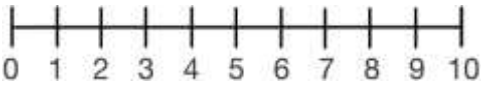
Do you connect with yourself? How and how often? *Hobbies/music/ meditation/ community service etc.*

On a scale of 1 to 10, please indicate for the past week:

How stressed you have been? *0 – not at all, 10 extreme*

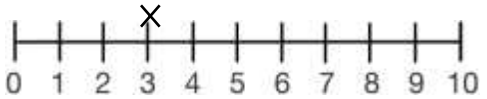


What is your energy level? *0 – very poor, I can barely get through the day, 10 – excellent, I can do more!*



Rate on a scale of 0 to 10, how hungry do you feel at different meal times?

0 – not at all 1-3 – mildly hungry 4-7 moderately hungry, 8-9 – quite hungry 10 – very hungry!



	Example	Morning	Mid-morning	Lunch	Snack	Evening	Dinner	Bedtime
Time	11am							
How hungry	8							

Rate on a scale of 1-5 how the following applies

If 1= Always, 2= Often, 3=Sometimes, 4=Rarely, 5=Never

	Rate	***If 3 or below, it indicates***
Is the above pattern mentioned irregular?		*Vāta (Vishama)*
Can you skip meals easily?		*Kapha/Āma (Manda)*
Are you mostly always ready to eat – whatever the time of the day it maybe?		*Pitta (Tikshna)*
If hunger is not gratified, do you feel uncomfortable or irritable?		*Pitta (Tikshna)/ (Vāta)*
Do you end up feeling fuller earlier than expected at the start of a meal?		*Āma/ Vāta (Manda/Vishama)*
Are there times when even little quantity of food doesn't get digested for a long time?		*Āma (Manda)*
Does your food get digested well on some days and sometimes not?		*Vāta (Vishama)*

Habits *Please indicate usage: none, light, moderate, or heavy. Add comments where significant.*

	Heavy	Moderate	Light	None	Comments
Alcohol	❑	❑	❑	❑	
Coffee	❑	❑	❑	❑	
Tea	❑	❑	❑	❑	
Tobacco	❑	❑	❑	❑	
Marijuana	❑	❑	❑	❑	
Other	❑	❑	❑	❑	

Personal preference

Which weather do you prefer?	Warm / cool/ both
Which extreme of weather are you unable to tolerate?	Hot / Cold / Neither
Which taste do you prefer?	Sweet/ Sour/ Salty/ Hot/ Bitter/ Astringent
How thirsty do you feel?	Often/ Moderate/ Not much
Do you sweat easily?	Often/ Not that much/ rarely

Please indicate below any symptoms you have experienced in the last three months:

General

- ❑ Poor appetite
- ❑ Cravings
- ❑ Change in appetite
- ❑ Peculiar tastes/smells
- ❑ Strong thirst – hot
- ❑ Strong thirst – cold
- ❑ Weight gain
- ❑ Weight loss
- ❑ Poor sleep
- ❑ Fatigue
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Fevers
- ❑ Chills
- ❑ Tremors
- ❑ Poor balance
- ❑ Localized weakness
- ❑ Bleed/bruise easily
- ❑ Sudden energy drop
- ❑ *Time(s) of day:*

Skin and Hair

- ❑ Rashes
- ❑ Skin tags
- ❑ Itching
- ❑ Change in skin/hair texture
- ❑ Hives
- ❑ Pimples
- ❑ Recent moles
- ❑ Loss of hair
- ❑ Dandruff
- ❑ Other skin/hair problems:

Head

- ❑ Dizziness
- ❑ Facial pain
- ❑ Migraines
- ❑ Headaches
- ❑ Other head/neck problems:

Eyes, Ears, Nose and Throat

- ❑ Glasses
- ❑ Poor vision
- ❑ Cataracts
- ❑ Eye strain
- ❑ Night blindness
- ❑ Blurry vision
- ❑ Color blindness
- ❑ Eye pain
- ❑ Spots in vision
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Earaches
- ❑ Nose bleeds
- ❑ Sinus problems
- ❑ Teeth problems
- ❑ Grinding teeth
- ❑ Recurrent sore throats
- ❑ Sore on lips or tongue
- ❑ Jaw clicks

Cardiovascular

- ❑ Swelling of feet
- ❑ Low blood pressure
- ❑ Difficulty breathing
- ❑ Irregular heartbeat
- ❑ Chest pain
- ❑ Fainting
- ❑ Dizziness
- ❑ Venous swelling
- ❑ Blood clots
- ❑ Cold hands
- ❑ Swelling of hands
- ❑ Cold feet
- ❑ Other problems with heart or blood vessels: _____

Respiratory

- ❑ Cough
- ❑ Coughing blood
- ❑ Pain with deep breath
- ❑ Difficulty lying down
- ❑ Phlegm color:
- ❑ Other:

Musculoskeletal

- ❑ Neck pain
- ❑ Back pain
- ❑ Shoulder pain
- ❑ Hand/wrist pain
- ❑ Hip pain
- ❑ Knee pain
- ❑ Foot/ankle pain
- ❑ Other muscle pain
- ❑ Muscle weakness

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Gas
- ❑ Belching
- ❑ Indigestion
- ❑ Bad breath
- ❑ Blood in stools
- ❑ Black stools
- ❑ Abdominal pain/cramps
- ❑ Chronic laxative use
- ❑ Other problems with stomach or intestines: _____

Genito – Urinary

- ❑ Frequent urination
- ❑ Pain on urination
- ❑ Blood in urine
- ❑ Urgency to urinate
- ❑ Unable to hold urine
- ❑ Decrease in flow
- ❑ Kidney stones
- ❑ Impotency
- ❑ Excessive sexual urge
- ❑ Do you wake up to urinate, how often?

Neuropsychological

- ❑ Lack of coordination
- ❑ Easily susceptible to stress
- ❑ Areas of numbness
- ❑ Treated for emotional problems
- ❑ Depression
- ❑ Bad temper
- ❑ Poor memory
- ❑ Anxiety
- ❑ Seizures
- ❑ Concussion
- ❑ Dizziness
- ❑ Loss of balance
- ❑ Other: _____ _____

Pregnancy and Gynecology

- ❑ Painful periods
- ❑ Clots
- ❑ Irregular periods
- ❑ Vaginal discharge
- ❑ Vaginal sores
- ❑ Breast lumps
- ❑ Premenstrual symptoms
- ❑ Unusual character (heavy or light)

- ❑ Use birth control
  *Type:*_____*How long:* _____
- ❑ No. of pregnancies: _____
- ❑ No. of births: _____
- ❑ No. of premature births: ____
- ❑ No. of miscarriages: _____
- ❑ No. of abortions: _____

- ❑ Age at first menses: _____
- ❑ Date of last menses: _____
- ❑ Menses duration: _____
- ❑ Length of full cycle: _____
- ❑ Date of last PAP: _____

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: _____

We keep medical records of the health care services we provide for you. You may ask to see and copy your records. You may ask to correct your records. **Your records will be kept confidential unless you give us written permission to release them or we are required to do so by law.**

We will ask you to sign a consent form allowing us to use and disclose your health information for purposes of consultations, payment and health technique operations in this office. You may see your records or get more information about them by contacting our office.

For more information about our privacy practices please inquire with us. By signing below, I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Signature of Rogi or Legal Representative Date

By checking this _____ I certify that typing my name is equivalent to my signature.

Healthy-You Ayurveda

Empowering Individuals to nourish both
mind and body for long-term health

Name: _____ Date: _____

Welcome to Ayurvedic Way. As you know, we are practitioners, faculties, and interns of Ayurveda. We are not licensed physicians, nor are Ayurveda services licensed by the state. Ayurveda is the 5000-year-old Wisdom of Healthy living. It is a way of natural healing and emphasizes on Maintaining the harmony of Body-Mind- Spirit through diet, lifestyle, and natural herbs. In Ayurveda the emphasis is not n a disease but on maintaining the balance of individual Body Constitution, so Ayurvedic treatments are never one size fits all, but they are custom tailored for each individual need. We are primarily a training institution and the services the wellness center provide are for education purposes. As a training institution our practitioners, faculties, and interns of Ayurveda, will provide you with the following kinds of services:

- Body- Constitutional Analysis
- Diet and the Lifestyle Counseling
- Ayurvedic Body Techniques
- Yoga and Meditation Practices

Our method of treatment in Ayurveda is alternative or complementary to conventional medicine. If you ever have any concerns of your Ayurvedic practices, please feel free to discuss them with us. We recommend that you inform your medical doctor that you are receiving Ayurvedic advice.

I have read and understood the above disclosure about the Ayurvedic services offered by practitioners of Ayurvedic Way Wellness center. I have disclosed with hem the nature of the services to be provided. I understand that the practitioners, faculties, and interns are not licensed physicians and the Ayurvedic services are not licensed by the state. I understand it is my responsibility to maintain a relationship for myself with a medical doctor.

_____ _____

Signature Date

By checking this ____ I certify that typing my name is equivalent to my signature.

Healthy-You Ayurveda

Empowering Individuals to nourish both
mind and body for long-term health

Missed Appointment Policy

Please give us at least 48 hours cancellation notice for an initial appointment, and 24 hours' notice for the follow up appointment. This allows us to call those waiting for an appointment to take your place.

If you do have health insurance that is accepted by our office, missed appointment are not billable to your insurance company. Unavoidable emergencies will be considered reasonable exceptions.

Please also be aware that the wellness allots a specific amount of time for each treatment and that if you arrive late, the length of your treatment will be adjusted to fit that schedule.

* NOTE: Cancellations for a Monday appointment must be made no later than 6:00pm that previous Friday.

A fee of $50.00 will be charged for missed appointment without adequate notice.

I have read and agreed to the missed appointment policy.

_____ _____

Signature Date

By checking this ____ I certify that typing my name is equivalent to my signature.

_____

Name

_____.

Signature of Parent or Legal Guardian
(If Patient is under the age of 18)