

Intake Form

Please print clearly

Name _____ Phone (h) _____ (w) _____

Address _____ City _____ St _____ Zip _____

Email address: _____ Occupation: _____

Sex _____ Height _____ Weight _____ Single _____ Coupled _____

Date of Birth _____ Time of Birth _____ Place of Birth _____

Contact in case of emergency: Name _____ Phone # _____

Policies

There is a \$15 service charge for all bounced checks. There is a \$15 fee for missed appointments and for canceling less than 24 hours before your appointment.

Disclaimer

This session is designed to inform you about the Ayurvedic viewpoint of various health concerns. It is in no way intended to diagnose or to prescribe treatment for any health problem. In the United States only a doctor can legally diagnose and prescribe treatment for disease. It is recommended that you discuss any Ayurvedic treatment method with your doctor before applying the treatment to yourself.

I have read and understand the above conditions _____

Signature

Date

Vata	Pitta	Kapha	Ama
<input type="checkbox"/> Dryness <input type="checkbox"/> Insomnia <input type="checkbox"/> Gas <input type="checkbox"/> Bloating <input type="checkbox"/> Constipation <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Muscle: Twitching, cramping, numbness <input type="checkbox"/> weakness <input type="checkbox"/> Joint Pain, Cracking <input type="checkbox"/> Stiffness <input type="checkbox"/> Shifting, tearing pain <input type="checkbox"/> Dry Cough <input type="checkbox"/> Cold Extremities <input type="checkbox"/> Dry Skin <input type="checkbox"/> Restlessness <input type="checkbox"/> Worry, Fear, Anxiety	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Loose Stool <input type="checkbox"/> Nausea <input type="checkbox"/> Migraines <input type="checkbox"/> Vomiting <input type="checkbox"/> Skin rashes, acne, hives, boils <input type="checkbox"/> Bruising <input type="checkbox"/> Excess Thirst <input type="checkbox"/> Burning, sharp pain <input type="checkbox"/> Spontaneous bleeding <input type="checkbox"/> Tenderness to touch <input type="checkbox"/> Excess body heat <input type="checkbox"/> Interrupted sleep <input type="checkbox"/> Anger, rage, envy <input type="checkbox"/> Judgmental, critical	<input type="checkbox"/> Congestion <input type="checkbox"/> Food or respiratory <input type="checkbox"/> Allergies <input type="checkbox"/> Edema <input type="checkbox"/> Heaviness <input type="checkbox"/> Dullness <input type="checkbox"/> Dull, vague pain <input type="checkbox"/> Cold Clammy hands <input type="checkbox"/> Difficulty sweating <input type="checkbox"/> Frequent urination <input type="checkbox"/> Excess oily skin <input type="checkbox"/> Excess sleep <input type="checkbox"/> Depression, greed, attachment <input type="checkbox"/> Mental Lethargy	<input type="checkbox"/> Coating on tongue <input type="checkbox"/> Low grade fever <input type="checkbox"/> Excess Sleep <input type="checkbox"/> Aches and pains <input type="checkbox"/> Malaise <input type="checkbox"/> Lethargy <input type="checkbox"/> Lack of energy <input type="checkbox"/> Lack of appetite <input type="checkbox"/> Sinking Stool

Chief concerns

Origin, duration and progress of the symptoms of chief concerns:_____

Place you were living when symptoms started:_____

Place of childhood:_____

Other places lived:_____

Please list any medications you are currently taking and what they are for:

History of any serious illness:_____

Family history, maternal:_____

Family history, paternal:_____

Substance Habits (addictions) like smoking or alcohol:_____

Sleep Habits:_____

Bowel Habits:_____

Urination Habits:_____

Please check all that apply to you.

- Appetite changeable**
- Appetite changes with travel or some disruption of routine**
- Sometimes can skip a meal without noticing or without needing to eat**
- Strong appetite usually but sometimes not**
- Appetite good and sometimes weak**
- Coating on tongue**
- Energy comes and goes**
- Tendencies for flatulence**

- Appetite is always strong**
- Need to eat three meals per day**
- Cannot skip any meal**
- Need to snack between meals**
- Excess thirst**
- Hypoglycemic tendencies**
- Irritable if meal comes late**
- Can eat heavy foods anytime of day**
- Can eat large meals anytime of day**
- Can digest anything**
- Tendency to diarrhea**
- Raw/undigested food in stool**
- Can eat much and often and can't / don't gain weight**

- Appetite is dull**
- Digestion takes 5-6 hours per meal**
- Can skip a meal easily**
- Don't eat breakfast or other meals regularly**
- Heavy foods are hard to digest**
- Large meals are hard to digest**
- Heaviness, dullness, lethargy after eating**
- Tendency to weight gain**
- Rarely snack**