

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?

AYURVEDA INTAKE

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Gas | <input type="checkbox"/> Belching | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Nausea or Vomiting |
| <input type="checkbox"/> Sleepy after Eating | <input type="checkbox"/> Heaviness after Eating | <input type="checkbox"/> Bloating after Eating |
| <input type="checkbox"/> Other | | |

Elimination

- | | | |
|---|--|--------------------------------|
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Alternating Constipation and Diarrhea | |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Rectal Pain or Hemorrhoids | |
| <input type="checkbox"/> Mucus in Stool | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Other |

Sleep

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Wake Periodically | <input type="checkbox"/> Light Sleep |
| <input type="checkbox"/> Sound Sleep | <input type="checkbox"/> Heavy Sleep | <input type="checkbox"/> Rise Refreshed |
| <input type="checkbox"/> Rise Tired | <input type="checkbox"/> Other | |

3. ENERGY:

- | | |
|---|---|
| <input type="checkbox"/> Sexual Energy | <input type="checkbox"/> Energy in Personal Relationships |
| <input type="checkbox"/> Energy in Professional Relationships | <input type="checkbox"/> Daily Energy |

Any questions concerns or comments? _____

AYURVEDA

Diet, Nutrition & Lifestyle Consultation
Body / Mind Constitution Assessment

*Check the most dominant or typical description

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

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Diet, Nutrition & Lifestyle Consultation Body / Mind Constitution Assessment

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

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Diet, Nutrition & Lifestyle Consultation Body / Mind Constitution Assessment

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

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Diet, Nutrition & Lifestyle Consultation Body / Mind Constitution Assessment

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