



Confidential Client History

Name: _____

Address: _____

City, State, Zip: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email: _____ Birth date: _____ Age: _____

Marital Status: _____ No. of Children: _____ Occupation: _____

Is there any possibility that you are pregnant? Yes No Possible

Are you nursing? Yes No

Family Physician: _____

How did you hear about The Healing Gardens of Ayurveda?
 Website Facebook Advertisement Referral Other _____

Objectives

Please check the items that reflect your main Objectives:

- I want an alternative approach to allopathic medicine for managing illness and disease
- I want to improve my general health and wellness and reduce my vulnerability to illness and disease
- I want to improve my lifestyle and dietary practices to improve my health
- I want to change my habits and behavioral patterns to improve my relationships with others
- I want to manage stress, tension and worry to attain a more stable emotional nature

What do you want to achieve or change in terms of your health and wellness?

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

Review of Concerns

List your chief complaint and any other significant symptoms that you are concerned about. If you have been diagnosed with any disease or condition, list these as well.

Chief Complaint:

Diagnosed Conditions:



Please check the digestive, elimination and emotional challenges that you experience. There are very important from an Ayurvedic perspective. Please indicate your current condition by (C) and general tendencies by (G) in each category.

Digestion

- | | | |
|---|--|--|
| <input type="checkbox"/> abdominal Pain | <input type="checkbox"/> Burning Indigestion | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Excessive Gas | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Sluggish after eating |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Smelly Gas | <input type="checkbox"/> Sleepy after eating |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Other: | <input type="checkbox"/> Other: |

Elimination

- | | | |
|---|---|--|
| <input type="checkbox"/> Constipation/Irregular | <input type="checkbox"/> Regular/Soft Stool
Diarrhea | <input type="checkbox"/> Regular/Oily/Mucus in Stool |
|---|---|--|

Psychology

- | | | |
|---|--|---|
| <input type="checkbox"/> Worry/Anxiety | <input type="checkbox"/> Irritable/Anger | <input type="checkbox"/> Lethargy/Slow Pace |
| <input type="checkbox"/> Fear | <input type="checkbox"/> Rage | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Spaceyness | <input type="checkbox"/> Jealousy/Envy | <input type="checkbox"/> Over attachment |
| <input type="checkbox"/> Insomnia/light sleep | <input type="checkbox"/> Moderate sleep (6-8hrs) | <input type="checkbox"/> Heavy sleep (8-10 hrs) |
| <input type="checkbox"/> Indecisive/Quick in making decisions
but changeable | <input type="checkbox"/> Decisive and focused | <input type="checkbox"/> Slow in making decisions
but steady |
| <input type="checkbox"/> Flying or fearful dreams | <input type="checkbox"/> Violent, fiery Dreams | <input type="checkbox"/> Romantic, watery dreams,
swimming |

Comments regarding symptoms listed above:



General Health and Lifestyle Patterns

1. Do you exercise regularly? yes no
Length of time: _____ times per week: _____
2. How much of the following do you drink? (Note: 1 cup = 8 ounces)
Water: number of cups per day: _____
Non-caffeinated beverages: number of cups per day: _____
Types: Herbal tea/milk/juice/other _____
Caffeinated beverages: number of cups per day: _____
Types: Coffee/tea/soda _____
Alcohol: number of cups per: day/week/month (please circle) _____
3. Do you currently smoke?
 Yes: How many cigarettes per day? _____
How long have you smoked for? _____
 No – Have you ever smoked? yes no. If yes, when did you quit _____
4. Any current or past use of addictive substances? yes no quit, when? _____
5. Do you experience allergic reaction to any substances (food, environmental etc)
Please explain: _____

6. What type of work do you do:

7. Please circle your work level of stress (1 = least, 5 = most): 1 2 3 4 5
Level of satisfaction: 1 2 3 4 5
8. Are you currently experiencing stress in any close relationship? yes no
If yes, level of emotional stress 1 2 3 4 5 (please circle)
9. Are you sexually active? yes no
10. Do you have any specific spiritual practices? Please describe:



Dietary Patterns

What kind of taste do you prefer? Please check one of the following:

1. Sweet/Sour/Salty
2. Sweet, Bitter, Astringent
3. Pungent, Bitter, Astringent

Any current or past chronic eating disorders or other food related issues? yes no

Please indicate your primary food choices and meal times:

<u>Meals</u>	<u>Time(s)</u>	<u>Typical foods and beverages</u>
Breakfast:	_____	_____
Lunch:	_____	_____
Dinner:	_____	_____
Snacks:	_____	_____

Current Medications, Herbs or Supplements

What medications are you currently taking or have taken recently, including birth control and hormone replacement therapy?

Have you noticed any significant changes?

Are you currently taking any Herbal Remedies or Supplements? Please list.



For Women Only

Menstrual History:

Your period is / was: [] Heavy [] Light

Cycle: [] 28 days [] 30 days [] other: please describe: _____

Menopause:

Do you have any pre/post menopausal symptoms? Please describe:



Medical History

Personal History:

Do you or your parents (indicate by P) have a history of: (check ailments that apply)

- | | |
|--|---|
| <p>Allergies to foods or drugs <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Anemia <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Arthritis <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Asthma, Pneumonia, TB <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Blood Pressure, high/low <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Cancer <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Chronic Constipation <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Chemotherapy/ Radiation <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Chest Pain <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Cholesterol, elevated <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Dental complications <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Diabetes <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Dizziness <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Epilepsy, convulsions, seizures <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Fainting <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Feet or ankle swelling <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Glaucoma, eye surgery <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Heart Attack <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Heart disease/ heart murmur <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Implant/Prosthesis <input type="checkbox"/> yes <input type="checkbox"/> no</p> | <p>Heart surgery <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Hepatitis A <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Hepatitis B <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Hepatitis Non-A/Non B <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>HIV Exposure <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Frequent attacks of colds/oughs <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Chronic Diarrhea <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Kidney or Bladder disease <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Mental Disorder <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Jaundice, Gallstone <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Ear pain or ringing <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Jaw pops, clicks or locks <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Prolonged bleeding when cut <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Rheumatic Fever <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Sinusitis <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Shortness of Breath <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Stroke <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Thyroid disease <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Ulcers, Intestinal bleeding <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Venereal Diseases <input type="checkbox"/> yes <input type="checkbox"/> no</p> |
|--|---|

Please explain any items checked:

Any Other Disease or Problems not listed above:

Have you been under the care of a licensed health care practitioner in the past year?

yes no. If yes, for what reasons:



Date of last physical exam:

Any past history of:

- | | |
|--|--|
| <input type="checkbox"/> serious injuries | <input type="checkbox"/> stress |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Emotional / mental stresses | <input type="checkbox"/> Mental clarity / concentration issues |
| <input type="checkbox"/> Troubled lifestyle conditions | <input type="checkbox"/> Vision problems, including dry eyes |
| <input type="checkbox"/> Changes in weight | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Aches, pains | <input type="checkbox"/> Cosmetic surgery |

Please describe any items checked:
