Ayurveda Healer
Wellness Spa

Health Seeker Intake Form

_____

Today's Date: Gender _M_F DOB:
Name: Height: Age:
Address:

_____

Email: Occupation:

__Married __Divorced Single __Widowed __Cohabitating

Emergency Contact Name & Phone:
Referred by:

_____

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?

Please describe the main problem(s) you would like help with today:
Overall health assessment.

———————————————————————————————

Describe problem:	Since:	Mild, moderate, or Severe:	Treatment & response:
1.			
2.			
3.			
4.			

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:	Since:	Control Status:	Treating physician, affiliation:
1.			
2.			
3.			

———————————————————————————————

Are you taking any prescription or herbal medications?

Medication:	Started in:	Dosage:	Prescribed by:
1.			
2.			
3.			

———————————————————————————————

Are you taking any vitamins or nutritional supplements? How often?

———————————————————————————————————————
1

———————————————————————————————————————
2.

———————————————————————————————————————
3.

———————————————————————————————————————

Were there any diseases that you suffered from earlier in life?

Disease:	From when to when:	Treatment-drugs, exercise, etc.

———————————————————————————————————————
1.

———————————————————————————————————————
2.

———————————————————————————————————————
3.

———————————————————————————————————————
Include major infections like typhoid, malaria, hepatitis:

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

Procedure:	When:	Who and where performed:

———————————————————————————————————————
1.

———————————————————————————————————————
2.

———————————————————————————————————————
Please list any hospitalizations

Year:	Condition:	Procedure done:

———————————————————————————————————————
1.

———————————————————————————————————————
2.

———————————————————————————————————————

How much do you move your body?

Activity Intensity Hours Days/week Since

_____

_____

_____

How often do you break a sweat with exercise?(times/week)

_____

How many hours do you watch TV/Computer every week?

_____

Do you watch TV/Computer, read or drive while eating meals?

_____

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

Please describe your sleep. Do you sleep sound, wake easily, or have a difficult time sleeping?

_____

_____

On a scale of 1 to 10, please indicate in the past week:
0-not at all, 10 extreme

How stressed you have been? 0----------10

What is your energy level? 0----------10

Rate on a scale of 0 to 10, how hungry do you feel at different meal times:
0=none, **1-3**=mild, **4-7**=moderate, **8-9**=quite, **10**=very!

Example: morning: lunch: snack: dinner: bedtime:
Time: 11am:

_____

Hunger: 8:

_____

Meals: *Please list what you ate in the last 24-48 hours.*

Breakfast:_____
Lunch:_____
Snacks:_____
Dinner:_____

Rate on a scale of 1-5 how the following applies:
1=always, **2**=often, **3**=sometimes, **4**=rarely, **5**=never *3 or below:

Rate:

Is your eating pattern irregular? ___ Vata (Vishama)

Can you skip meals easily ___ Kapha/Ama (Manda)

Are you mostly always ready to eat-
whatever the time or day, it may be? ___ Pitta (Tikshna)

If hunger is not gratified, do you feel
uncomfortable or irritable? ___ Pitta (Tikshna) Vata

Do you end up feeling fuller earlier than
expected at the start of a meal? ___ Ama/Vata
(Manda, Vishama)

Are there times when even little quantity of
food doesn't get digested for a long time? ___Ama(Manda)

Does your food get digested well on
some days and sometimes not? ___ Vata (Vishama)

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

	Heavy	Moderate	Light	None	Comments
Alcohol	__	__	__	__	_____
Coffee	__	__	__	__	_____
Tea	__	__	__	__	_____
Tobacco	__	__	__	__	_____
Marijuana	__	__	__	__	_____
Other	__	__	__	__	_____

_____

Personal Preference:	**Circle**:
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	__Weight gain/loss	__Fevers
__Cravings	__Poor sleep	__Chills
__Change in appetite	__Fatique	__Tremors
__Peculiar tastes/smells	__Night sweats	__Sudden
__Strong thirst hot/cold	__Sweat easily	energy drop
__Localized weakness	__Bleed/bruise easily	time of day__

Skin & Hair

__Rashes	__Change in skin/hair texture	__Pimples
__Skin tags		__Recent moles
__Itching	__Loss of hair	__Other skin/hair
__Hives	__Dandruff	problems:

Head

__Dizziness	__Migraines	__Other head/neck
__Facial pain	__Headaches	problems:

Eyes, Ears, Nose, & Throat

__Glasses
__Poor vision
__Cataracts
__Eye Strain
__Night blindness
__ Sore throat recurrent
__Blurry vision
__Color blindness
__Eye pain
__Spots in vision
__Ringing in ears
__Sores on lips or tongue
__Poor hearing
__Ear aches
__Nose bleeds
__Sinus problems
__Teeth problems
__Grinding teeth
__Jaw clicks

Cardiovascular

__Swelling of feet/hands
__Low blood pressure
__Difficulty breathing
__Irregular heartbeat
__Chest pain
__Fainting
__Dizziness
__Venous swelling
__Blood clots
__Cold hands/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
__Other:

Gastrointestinal

__Nausea
__Vomiting
__Diarrhea
__Constipation
__Gas
__Belching
__Indigestion
__Bad breath
__Blood in stools
__Black stools
__Abdominal pain cramps
__Chronic laxative use
__Other problems w/ *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

__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

Pregnancy and Gynecology

__Painful periods
__Clots
__Irregular periods
__Vaginal discharge
__Vaginal sores
__Breast lumps
__PMS
__Unusual character heavy/light
__Use birth control Type____how long___
__No. Pregnancies
__No. Births
__No. Premature births
__No. Miscarriages
__No. 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