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
__Dryness __Insomnia __Gas __Bloating __Constipation __Hemorrhoids __Muscle: Twitching, cramping, numbness __weakness __Joint Pain, Cracking __Stiffness __Shifting, tearing pain __Dry Cough __Cold Extremities __Dry Skin __Restlessness Worry, Fear, Anxiety	__Diarrhea __Loose Stool __Nausea __Migraines __Vomiting __Skin rashes, acne, hives, boils __Bruising __Excess Thirst __Burning, sharp pain __Spontaneous bleeding __Tenderness to touch __Excess body heat __Interrupted sleep __Anger, rage, envy __Judgmental, critical	__Congestion __Food or respiratory __Allergies __Edema __Heaviness __Dullness __Dull, vague pain __Cold Clammy hands __Difficulty sweating __Frequent urination __Excess oily skin __Excess sleep __Depression, greed, attachment __Mental Lethargy	__Coating on tongue __Low grade fever __Excess Sleep __Aches and pains __Malaise __Lethargy __Lack of energy __Lack of appetite __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 reguarly**
____ **Heavy foods are hard to digest**
____ **Large meals are hard to digest**
____ **Heaviness, dullness, lethargy after eating**
____ **Tendency to weight gain**
____ **Rarely snack**