Client Intake Form

Name:_____

Address:_____

City, State, Zip:_____

Telephone—Home:_____ Work:_____E-mail:_____

Birth date:_____ Birth place: _____ Age:__

Place of childhood: _____

Marital/partner status:_____# of children:_____Ages:_____

Occupation: _____ Blood type: _____ Height: _____ Weight: _____

How did you hear about Ayurveda Yoga? : Website/Referral/Friend/other.....

1. Payment for consultation is done in advance. Please note that Ayurveda is NOT recognized in US as a medical system. Only, as a alternative health system. Please consult your physician before beginning any 'detox' panchakarma program or 'yoga' therapy, herb protocols or diet program. Ayurvedic Herbs are not evaluated by the FDA, and are herb supplements, not medicines- intended to diagnose, treat, cure or prevent any disease or disorder in any way or form.
2. Note that all healthcare products and services offered by our practitioners, or websites, are not intended to replace your own doctor's advice or any other medical recommendation. Neither is Ayurveda Yoga llc to be held responsible, in any shape or form, for the applicability of any opinions or recommendations with respect to your or your dependent/child symptoms or medical condition.

3. Herb protocols, Dietary consideration and Panchakarma services may be recommended. Half of payment for those services is due before the appointments are scheduled.

4. If you miss an appointment with your clinician without giving 24 hours notice, a $20 fee is charged to your account.

I have read and understood everything, and, start my Ayurvedic Lifestyle coaching program, and take full responsibility for myself.

Client's Signature: _____Date:_____

AYURVEDA LIFESTYLE COACHING PROGRAM

1. *Intention of Program: To educate you about your individual constitution and assist you in bringing yourself back to balance and harmony with the laws of nature. As you begin to move towards balance, you become more conscious and your natural, innate intelligence wakes-up, you begin to naturally make choices that are nurturing, healing, and balancing. You will be educated and empowered to take charge of your own health, and begin to develop the awareness to bring balance and health to each moment of your life, restoring you to your true joyful nature and present to the beauty and magic of life.*

2. *Outline of Services: 1 hour Consultation; an opportunity to assess your current physical, mental and spiritual routines, your prakruti (fundamental state of balance) and your vikruti (current imbalance). I will begin to educate you on your individual constitution and the basics of Ayurveda. You will be introduced to new practices as part of your plan for achieving balance. Practices may include meditation, yoga, dietary adjustments and breathing exercises all designed to further your education, awareness and ability to bring balance to your life. Periodic 45 min. follow-up sessions will be recommended to monitor and support your progress. In this way you can integrate lifestyle changes over time and we can make any adjustments needed in your program.*

3. *Ayurveda is not about instantaneous results, although you will see many immediate benefits. In accordance with the laws of nature, it will take time to gently restore full balance. Life is dynamic and we are part of life. We continually need to modify our lifestyle to the changing seasons, emotions, stresses etc. to achieve balance. Ayurveda is not a passive form of therapy but rather asks each individual to take responsibility for his or her own daily living. Using the ancient wisdom of Ayurveda I will educate, empower and support you as a dynamic individual, but it is up to you to bring this into your daily life. It is a simple, natural science that takes time, as it takes time for the stream to wear the stone smooth, but gently, over time it changes form completely. It is amazing the difference a small adjustment in your diet or lifestyle can make to create greater well-being. I am excited and honored to assist you in discovering your uniqueness and create a balanced life with radiant health and a peaceful mind.*

4. *Requirement of Client:*
   A. *24-Hour Cancellation Notice. Less than 24 hours notice will require a $20.00 rescheduling fee.*
   B. *Payment of Ayurvedic Consultation is $60.00. Payment is expected in full during our initial Ayurvedic Consultation.*

Client Signature: _____

Ayurvedic Practitioner: _____

Please take quiet time and space to answer these questions. Take this as an opportunity to bring awareness to areas of your life that may need more loving attention. Use a separate sheet of paper if needed.

1. *What are you currently doing in your life that brings you peace, health, balance and/or nurtures your soul?*

2. *What would you like to get out of the Ayurvedic Consultation?*

   a)

   b)

2. *Where in your health, life, and relationships (to self and others) do you experience a lack of freedom, balance, and joy?*

3. *Which areas in your life are you most interested in bringing balance to?*

4. *If you achieved a perfect state of health, which is balance between your fundamental energies, or "doshas" and your body, mind and soul or consciousness, what would your life look like? How would you feel? What would you be doing? What would be different? Paint a picture for yourself.*

5. *What results do you want to produce in your physical body?*

6. *What results do you want to produce in regards to your mental and emotional well-being? Do you find yourself anxious, stressed, depressed, or easily brought to annoyance or anger?*

7. *What do you want your spiritual life to look like?*

8. *How can I best support you in achieving the health, vitality, and balance you want in your life?*

9. *What would you have to give up to have the results you want?*

CHIEF HEALTH CONCERNS

What are your main health concerns at this time? Order by importance to client.

PRIMARY CONCERNS	CLINICIAN NOTES
1.	
2.	
3.	
4.	
5.	
6.	

PAST MEDICAL HISTORY

Include major conditions, dates of treatment and procedures performed.

1. Serious illnesses:_____

_____

2. Hospitalizations:_____

3. Operations:_____

4. List other pertinent past conditions:_____

_____

5. Have you been under the care of a licensed health care professional in the past year? ☐ **Yes** ☐ **No**

If so, for what reasons:_____

6. Is there any possibility that you are pregnant? ☐ Y ☐ N

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DATION

NAME: Anonymous **DATE:**

SEX: M F

Ayurvedic Age: Kapha, Pitta, Vata

Find the Dosha, Prakruti, Vikruti of the case study.

Prakruti: V P K

Vikruti: V P K

PARIKSHA:
Sub Doshas: Chart on the right
Agni:
Low Agni - (low apetite, slow digestion Kapha)
Irregular Agni - (irregular apettite, gas, constipation, Vata)
High Agni (Prone to Acidity, OR, 2 or more bowel movements, Pitta)

Common Health Issues

SYMPTOMS
Prana (Low Energy, Variable, Fatigue)
Tejas (No Radiance, Lack of Lustre)
Ojas (low immunity, weight loss)

FINDINGS:
NADI: Left Hand: Index, Middle, Ring

Right Hand: Index, Middle, Ring

DHATU: Rasa, Rakta, Mamsa, Meda, Asthi, Majja, Shukra

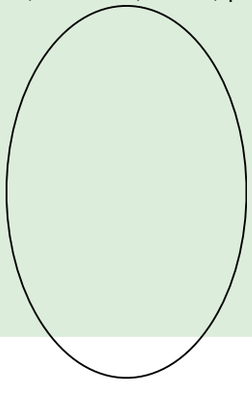
Srota: Pranavaha, Annavaha, Udaka, , Rasavaha, Raktavaha, Mamsavaha, Medavaha, Majja, Shukra, Artava, Purisha, Mutra, Sveda

AMA INDEX: 1, 2, 3, 4, 5
Tired, Fatigue, even after a full night sleep, lack of clarity, heavyness, slow digestion

Coating on Tongue: White, Yellow, Chalk Brown

NAILS: Brittle, No moon, bluish, pink, white spots, striations

Tongue



SUB DOSHAS PITTA

PITTA	BHRAJAKA	RANJAKA	ALOCHAKA	PACHAKA	SADHAKA
Location - Small intestines, liver, gallbladder lower part of the stomach, spleen and pancreas	Skin	Liver	Eyes	Digestion -	Brain, Mind
	NOTES				
	Redness, Oily, Rosacea, Adult Acne,	Low RBC count. Anaemia	Redness of eyes, sensitivity to the sun	High Pachaka - Hyperacidity, Acid Reflux, Diarhoea	Lack of clarity, memory lapse, unable to process too much information or thoughts
				Low pachaka - Lack of digestive enzymes. GI Tract issues	

SUB DOSHAS VATA

VATA	PRANA	VYANA	SAMANA	UDANA	APANA
Location – Colon, bladder, thighs, hips, legs & kidneys.	Notes				
COUNT	Low Energy, lack of clarity, Fatigue, Feeling tired all the time	Low or high blood pressure, congested lymph, unable to form intimate relationships, or, relationship issues with family (everyone in the family)	Digestive issues. Feeling of heaviness in the stomach. Slow peristalsis of food and it takes long time to digest. Low appetite.	High - Talking too much. (Balanced - Good speaker)	Low Apana - Constipation, Dryness, Gas, Low Menstrual Fluid, Irregular periods
				Low - Unable to express oneself. Low voice/shabda. Lack of communication. Emotional Issues.	High Apana - loose stools, 2-3 bowel movements or more, heavy bleeding during menses, P.C.O.S., G.E.R.D

SUB DOSHAS KAPHA

KAPHA	KLEDAKA	SHLESHAKA	AVALABAKA	BODHAKA	TARPAKA
Lungs, upper part of the stomach, heart, tongue and oesophagus	Notes				
	lack of appetite and mucosa, dryness in mouth. Usually goes hand in hand with Bodhaika kapha	dryness in joints, j	May manifest as possible heart and lung congestion	Imbalanced - Lack of Taste, Lack of Salivary Enzymes, Lack of appetite, Dryness in mouth	Blocked Sinus. Sinus headaches.

DAILY ROUTINE

DAILY SCHEDULE *(include approximate times)*

1. *Describe your activities from the time you wake up until you go to sleep. (Eating, sleeping, exercise, work, activities).*

	Time	*Activities*	
Morning			*VARIATIONS*
Awaken			
Breakfast			
Activities			
Mid-day			
Lunch			
Activities			
Evening			
Supper			
Activities			
Night			
Activities			
Bed-time			

2. *List regular practices that are not included in the above schedule, e.g., exercise, meditation, spiritual practices, etc.*

3. *Are you sexually active? Y ☐ N ☐ Frequency?*

4. *Other comments about daily routines:*

5. *What types of food(s) are eaten on a regular basis?*

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

6. *Are there any routines around eating:*

7. *Any current or past problems with chronic eating disorders or other food related issues?* ☐ ***Y*** ☐ ***N***

ALLERGIES OR SENSITIVITIES

8. *Do you have allergic reactions to any substances? If yes, please list.*

GENERAL HEALTH HABITS

9. *How many cups of caffeinated beverages do you drink per day?*
 # _____ Type(s) of beverage: coffee/tea/soda

10. *How many cups of non-caffeinated beverages do you drink per day? # _____*
Type(s) of beverage: herbal tea/milk/juice/other _____

11. *How much water do you drink per day?_____*

12. *Do you exercise regularly? q Y q N Length of time: _____*
Times per week: _____Type(s) of exercise: _____

13. *If you smoke, how many cigarettes do you smoke per day? _____Have you ever smoked? q Y N q*
Amount/day: _____ When quit? _____

14. *If you drink alcohol, how many glasses of alcohol per week?* (Include beer, wine, liqueurs and hard liquor) *# _____per week Type(s) of beverage:_____*

15. *Any current or past problems with addiction or substance abuse? q Y q N*
Substance: _____ Amount: _____ When quit? _____

16. *Please describe current digestive patterns (i.e. regular/irregular B.M., diarrhea, constipation, indigestion, strong/dull appetite): _____*

17. *Body temperature: Do you generally run warm or cold? Please explain:*

REVIEW OF SYMPTOMS

Check all symptoms that are of concern to you at this time that you want to discuss with the practitioner. Please indicate any area in which you have experienced a severe episode and indicate if episode was in previous 6 months or prior to 6 months time.

Concern	Office	HEAD
		Headaches
		Dizziness
		Fainting spells
		Loss of balance
		Difficulty remembering
		Difficulty thinking clearly
		Thinning or loss of hair

Concern	Office	EARS
		Hearing loss
		Ringing
		Earaches–Pain
		Discharges
		Bleeding

Concern	Office	EYES
		Pain–soreness in eyes
		Redness
		Burning
		Mucous
		Dryness
		Itching
		Tic/twitch
		Blurred/loss of vision

Concern	Office	MOUTH
		Excessive thirst
		Loss of taste
		Strange taste
		Bad breath
		Lip ulcers or lesions
		Dry/cracking lips
		Tongue pain
		Bleeding gums
		Receding gums
		Tooth pain
		TMJ

Concern	Office	NECK
		Pain
		Swollen glands
		Lumps
		Stiffness

Concern	Office	CHEST
		Pain in chest
		Tightness/pressure in chest
		Heart palpitations
		Shortness of breath
		Painful–difficult breathing
		Persistent cough
		Frequent chest colds

NOSE

Concern	Office	
		Loss of smell
		Bleeding
		Pain
		Discharge
		Post-nasal drip
		Sinus Congestion

SKIN

Concern	Office	
		Dry–flakey
		Rashes
		Blisters
		Acne
		Changing or bleeding moles
		Response to insect bites

DIGESTION

Concern	Office	
		Pain
		Burning indigestion
		Belching
		Regurgitation
		Vomiting
		Excessive Gas
		Heavy–Bloaty after eating
		Hemorrhoids
		Constipation (< 1 BM/day)
		Diarrhea
		Both constipation & diarrhea
		Bloody Stool

CIRCULATION

Concern	Office	
		Varicose veins
		Cold hands–feet
		Swollen ankles
		Calf pain
		Puffy eyes

FEMALE SYSTEM

Concern	Office	
		Irregular cycle
		Heavy/prolonged bleeding
		Missed menses
		Painful menses
		Spotting
		Discharge
		PMS symptoms
		Pregnant
		Miscarriage
		Infertility
		Genital sores
		Ovarian cyst
		Fibroids

URINARY

Concern	Office	
		Loss of urination control
		Painful urination
		Urine retention, dribbling
		Daytime urination often
		Nighttime urination often
		Blood in urine

		Pain in kidney/groin area
		Kidney/bladder infections

Concern	Office	MUSCLES&JOINTS
		Swelling in joints
		Pain/ache in joints
		Stiff joints
		Persistent muscle/bone pains
		Tremors/tics in muscles
		Muscle weakness/atrophy

Concern	Office	NERVES
		Loss of taste, smell or touch
		Tingling sensations
		Tremors in limbs
		Uncoordinated muscle/limbs

Concern	Office	BREASTS
		Swelling
		Redness
		Lumps
		Nipple discharge
		Tenderness–pain

Concern	Office	MALE SYSTEM
		Prostate gland swollen/painful
		Low sperm count
		Low motility
		Genital sores or lesions
		Genital discharge
		Erection difficulty