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Confidential Client Intake Form

Name: _____

Address: _____

City, State, Zip _____

Tel. Home: _____ Cell: _____ Work: _____

Email: _____ Birthdate: _____ Age: _____

Birthplace: _____ Place of Childhood: _____

Marital/Partner Status: _____ # of Children: _____ Ages: _____

Occupation: _____

How did you hear about Embrace Ayurveda? _____

May we add your email address to our eNewsletter list? We typically send 1-2 emails per month. Yes No

WHAT YOU CAN EXPECT FROM YOUR AYURVEDIC HEALTH CARE

Ayurveda is an ancient healing system from India which recognizes that each person's path toward optimal health is unique. The intention of the Ayurvedic Consultation is to educate you about your individual constitution and assist you in bringing yourself back to balance and harmony with the laws of nature. Ayurveda is not a passive form of therapy but rather asks each individual to take responsibility for his or her own daily living.

You will be introduced to new practices as part of your program for achieving balance. Your program may include meditation, yoga, dietary adjustments, breathing exercises, Ayurvedic treatments and cleansing therapies. A follow-up program will be recommended to support you in successfully integrating these practices into your life. You will begin to develop the awareness to bring balance and health to each moment, restoring you to your true joyful nature.

Agreements:

1. Payment of Ayurvedic Consultation is \$225.00 which includes an initial 1.5 hours consultation and 1-hour follow-up session.
2. 24-Hour Cancellation Notice. If you miss an appointment with your practitioner without giving 24 hours notice, you will be charged full value for the appointment.
3. Payment is expected in full during our initial Ayurvedic Consultation. Payment can be made by cash, check or major debit/credit card.
4. Embrace Ayurveda does not bill insurance companies for any service.

Client's Signature: _____	_____	Date: _____	_____
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Informed Consent

To receive alternative health care through Embrace Ayurveda. All clients who participate in Ayurvedic health care through Embrace Ayurveda should be advised of the following:

1. Embrace Ayurveda is not a primary care medical clinic.
2. Your Ayurvedic Practitioner is not a Medical Doctor, is not trained in Western medical diagnosis, and may not prescribe or alter your medication.
3. Your practitioner is evaluating your findings from an Ayurvedic perspective. This examination does not take the place of a medical evaluation.
4. I understand there will be no diagnosis made or prescription given, but the Ayurvedic Practitioner will offer an assessment of my general health and will make dietary, herbal and nutritional recommendations.
5. I take full responsibility for my health and well-being and freely choose to incorporate any recommendations at my own discretion.

I have read and understand the above information.

Client's Signature:		Date:	
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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.

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?
3. If you achieved a perfect state of health, what would your life look like? How would you feel? What would you be doing? What would be different? Paint a picture for yourself.
4. How can I best support you in achieving the health, clarity, and balance you want in your life?
5. Is there anything you know you need to give up or bring in to have the results you want?

Health Concerns

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

1.	
2.	
3.	
4.	
5.	
6.	

Past Medical History

Please list any major condition(s) and dates of diagnosis, treatment, and procedures performed.

Are you under the care of a licensed health care professional or any other healthcare provider? Yes No

If so, for what reason(s)? _____

Serious Illnesses: _____

Hospitalizations: _____

List other pertinent current or past conditions: _____

Have you had any cosmetic or dental surgery or other procedures performed? Yes No

If so, please list: _____

Family History

Indicate which members of your immediate family have had these conditions.

High Blood Pressure		Heart Disease		Other	
Cancer		Mental Disorder			
Stroke		Diabetes			
Notes:					

Current Medications, Herbs, or Supplements

What medications, herbs, and supplements are you currently taking? Please include significant remedies that you have stopped taking, including birth control and hormone replacement therapies.

Substance	Over-the-Counter or Prescription?	Herb/Drug/Vitamin?	Prescribed by? (ie: self, MD)	For what purpose?	For how long?	What dosage?	What have the benefits been?
	Prescription	Herb	Self				
	Prescription	Herb	Self				
	Prescription	Herb	Self				
	Prescription	Herb	Self				
	Prescription	Herb	Self				
	Prescription	Herb	Self				
	Prescription	Herb	Self				
	Prescription	Herb	Self				

Regular Practices

Exercise _____

None/Never
 Occasional
 Several Times/Week
 Daily
 Several Times/Month

Yoga _____

None/Never
 Occasional
 Several Times/Week
 Daily
 Several Times/Month

Spiritual Practices (specify) _____

None/Never
 Occasional
 Several Times/Week
 Daily
 Several Times/Month

Travel (include commute if applicable) _____

None/Never
 Occasional
 Several Times/Week
 Daily
 Several Times/Month

Daily Schedule

What are your habitual activities from the time you wake up until you go to sleep? Include mealtimes, sleeping, exercise, work, and any activities that occur on a regular basis.

	Time	Habitual Activities	Notes	
Morning				
Awaken				
Mealtime				
Activities				
Day				
Mealtime				
Activities				
Night				
Mealtime				
Activities				

Habits

- Are you a smoker? Yes No Years? _____ Amount? _____
- Have you smoked in the past? Yes No When did you quit? _____
- Do you use recreational drugs? Yes No If yes, what types? _____ How often? _____
- Do you drink alcohol? Yes No If yes, what types? _____ How often? _____
- Do you drink coffee? Yes No Cups/day? _____
- Do you drink caffeinated/herbal tea? Yes No Cups/day? _____
- Do you make a point to drink water daily? Yes No Glasses/day? _____
- Any current or past addictive or habitual substances? Yes No Specify: _____

Daily Nutrition

What types of food are eaten on a daily basis?

Breakfast	
Lunch	
Dinner	
Snacks	
Eating Routines?	

Allergies or Sensitivities

Do you have allergic reactions to any substances (including pollen, food, medicines)? If yes, please list:

Are there any foods you regularly avoid eating because they give you symptoms? If so, how long after eating do symptoms occur?

Gastro-Intestinal

- | | | | |
|---------------------------------------|---|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Bloating | <input type="checkbox"/> Colitis/IBS |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas | <input type="checkbox"/> Food cravings | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Black stools | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Poor appetite | |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Gallstones | |

Elimination

How many bowel movements do you have a day?

<1 1 2 3 4+

How would you describe your bowel movements?

loose normal hard tarry

Do your stools:

float sink have a bad odor have no odor display blood?

Do you rely on:

enemas laxatives purgatives for bowel elimination?

If yes, how often? (Times per week?) _____

Any other digestive problems? _____

Any current or past chronic eating disorders or other food related issues? Yes No

Explain: _____

Appetite (Agni)

Variable: Sometimes I'm not hungry, but if I don't eat, I get low blood sugar, light-headed, dizzy or shaky.

Sharp: Ravenous, I have to eat now! I get irritable if I don't eat.

Dull: I like to eat. No big deal if I skip a meal.

Sama: Steady, consistent appetite at meal times. I feel satisfied after a meal.

Time of day you're most hungry: _____

Energy

High Low Variable Dips

How much energy do you have? Scale of 1-10: _____

Does it change? Yes No Do you take naps? Yes No How often? _____ How long? _____

Describe any energy issues you have? _____

Sleep Patterns

Describe your sleep patterns

What time do you regularly go to bed? _____

What time do you regularly go to sleep? _____

Is it easy to fall asleep? Yes No

Is it easy to get up in morning? Yes No

Do you get hot while sleeping? Yes No

Do you wake during the night? Yes No

How often? _____ What time? _____

Is it easy to go back to sleep? Yes No

Describe any sleep issues you have:

If you experience sleep challenges what do you think is the primary cause?

Vitals

Height: _____ Weight: _____ Has it changed in the last year? Yes No

Most comfortable weight? _____

Body Temp: warm cool variable steady

Cold hands and feet? Yes No

Easily flush? Yes No

Overheat? Yes No

Blood pressure: low high normal?

Mind, Emotions and Relations

How do you feel about the following areas of your life? Please check appropriate boxes.

	Excellent	Good	Fair	Poor	Comment
Self esteem					
Spouse/Partner					
Sex					
Family					
Life Purpose					
Finances					
Work					
Enthusiasm for life					

Are you able to express your feelings and emotions easily? Yes No

How would you rate your stress level on a scale of 1-10? _____

Is there something you are not doing that you have been wanting to do for a long time or something you are doing that you know is depleting your energy?

Female Reproductive

- Discharge, if yes what is the color? _____
- | | | |
|---|--|--|
| <input type="checkbox"/> Genital herpes | <input type="checkbox"/> Vaginal itching | <input type="checkbox"/> Pain with intercourse |
| <input type="checkbox"/> Cervical dysplasia | <input type="checkbox"/> Anemia | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Pelvic inflammatory disease | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> Uterine cysts | <input type="checkbox"/> Infertility | <input type="checkbox"/> Lumpectomy |
| <input type="checkbox"/> Fibroids | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Vaginal infection |

Do you have premenstrual symptoms (PMS)? Yes No

How many days before your cycle do symptoms begin to manifest? _____ days before period

If you have PMS, which symptoms apply to you?

- | | | |
|---|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Grief |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Headaches | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Nervous tension | <input type="checkbox"/> Bloating | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Craving for sweets | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Water retention | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Depression | <input type="checkbox"/> Joint pain |

Do you menstruate? Yes No

What is the length of your cycle? _____ days. Duration of bleeding? _____ days.

Would you characterize your flow as: Heavy Normal Light

Is the blood: Dark Normal Light

How many: pregnancies have you had? _____

Births? _____ Miscarriages? _____ Premature births? _____ Abortions? _____

Do you or have you recently used contraceptives? Yes No

If yes, which ones?

If you have menopausal symptoms, please describe your major symptoms:

Do you have any other gynecological issues?

Health Concerns:

Please check off those issues you have experienced in the last 3 months.

Skin and Hair

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Poor healing sores | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Pimples | <input type="checkbox"/> Acne | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Hair loss | <input type="checkbox"/> Recent moles | <input type="checkbox"/> Recent changes in skin texture |

Any other noted problems with your skin, nails or hair? _____

Head, Eyes, Ears, Nose and Throat

- | | | |
|---|--|---|
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Cold sores, if yes how often? ___times/year | <input type="checkbox"/> Floaters |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Clicking jaw | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Mucous in throat |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Canker sores |

Any other problems with your head, eyes, ears, nose or throat? _____

Cardiovascular

- | | | |
|--|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest/heart pain |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Cold hands or feet |
| <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Easy bruising |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Breathing difficulties |

Any other problems with your heart or circulation? _____

Respiratory

- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> Hay-fever | <input type="checkbox"/> Cough | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Pain on breathing | <input type="checkbox"/> Shortness of breath without exertion | |
| <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> Production of phlegm, if yes what color? _____ | |

Any other problems with breathing? _____

Genito-urinary

- | | | |
|--|--|--|
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Urgency of urination | <input type="checkbox"/> Kidney/bladder stones | <input type="checkbox"/> Irregular flow |
| <input type="checkbox"/> Inability to hold urine | <input type="checkbox"/> Decrease in flow | <input type="checkbox"/> Water retention |
| <input type="checkbox"/> Burning urine | <input type="checkbox"/> Difficulty stopping or starting | <input type="checkbox"/> Interstitial cystitis |
| <input type="checkbox"/> Prostate enlargement | <input type="checkbox"/> Erectile dysfunction | |

Any other problems with urination? _____

Musculoskeletal

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Reduced range of movement | | |

Neuropsychological

- | | | |
|---|--|---|
| <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Migraine | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> High stress levels | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Lack of coordination |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Foggy or spacey feeling | <input type="checkbox"/> Muscle spasm/twitching |

Do you have any other neurological problems? _____

Metabolic

- | | | |
|--|--|---|
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Slow metabolism |
| <input type="checkbox"/> Sudden energy drops | <input type="checkbox"/> Intolerance to heat or cold | <input type="checkbox"/> Recent weight gain |
| <input type="checkbox"/> Recent weight loss | | |

Thank you for taking the time to fill out this form. I am looking forward to supporting you to create the health and life you want.

Namaste,

Sarah