REGISTRATION & CONTACT INFORMATION

Dr. Cynthia Senter, ND | Dr. Alexandra Porter, ND | Dr. Lindsey Harding, ND
Positive Touch Medicine | 929 N 130th St, Ste 6 | Seattle, WA | 98133
Phone: 206-547-5510 | Fax: 206-547-5517 | www.positivetouchmedicine.org

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Patient Name____________________________________**Preferred name** _________________
First M Last

Date of Birth____/____/________**Age**______**Sex** □ Male □ Female **Date of First Visit**____/____/________
MM DD YYYY

Street address ____
Street Apt/Suite/Unit #

____
City State ZIP Code

Preferred phone number: (_______)________-______________**Phone type:** □ Home □ Cell □ Work □ Other

Alternate phone number: (_______)________-______________**Phone type:** □ Home □ Cell □ Work □ Other

Email____**Communication Preference:** □ Phone □ Email

Occupation & Employer:______________________________Work phone: (__________)________-___________

Marital Status □ Single □ Married □ Other **Name of Spouse/Partner** ____________________________________

Name of parent/legal guardian (if 17 years or younger) ____

Insurance Information
skip if providing card

Company:____________________________________

ID or SS #: __________________________________

Group #: ____________________________________

Plan name: __________________________________

Subscriber name: ______________________________

Subscriber date of birth:_____/_____/____________

Subscriber's employer: ___________________________

Emergency Contact Information
required

Emergency Contact 1 ______________________________

Relationship______________________________________

Contact phone # (______)________-__________________

Emergency Contact 2 ______________________________

Relationship______________________________________

Contact phone # (______)________-__________________

STATEMENT OF HEALTH PLAN, BILLING POLICY, AND SCHEDULING POLICY AGREEMENT:

I, the undersigned, understand that payment is expected in-full at the time of service, including all co- pay or deductible amounts for insurance billing. I authorize treatment of the person named above and agree to pay all fees for such treatment. I have been informed of the fees for services. I hereby authorize the clinic to receive all benefits to which I and/or my dependents are entitled to under my health insurance plan. In addition, I will not withhold or delay payment if my insurance company denies payment on any of my charges. I have been informed of the $35.00 fee on all checks returned by my bank NSF (per RCW 62A, 3-515 & 520). The undersigned agrees that whether he/she signs as an agent, he/she is obligated to pay for the account. Should the balance of the account exceed an amount the undersigned is able to pay in full within 60 days, a $5.00 per visit/per month rebilling fee will be applied (per RCW19.52). I also understand that by signing this document I abide by the policies of the clinic, including the scheduling policies outlined on the reverse side of this page.

____ ________________________
Signature of patient or parent/legal guardian Date signed

APPOINTMENT POLICY
PATIENT NON-DESCRIMINATION POLICY

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MISSED APPOINTMENTS

Positive Touch Medicine requires *at least* 24 hours' notice of cancellation for all appointments. This ensures maximum availability for our patients by allowing the office staff time to notify those who may be waiting for an appointment**.**

A minimum of $75.00 up to the cost of a full visit ($150.00) will be charged for missed or cancelled appointments without adequate notice. **Please note that these missed appointment fees are not billable to your health plan; these charges are an automatic out-of-pocket patient responsibility**.

This policy applies to all patients, except in the case of unavoidable emergencies.

LATE ARRIVALS

The clinic allots a specific amount of time for each treatment. In the event of a late arrival, the length of your treatment will be adjusted to that time allotment. Please call the clinic if you know that you are running late. After 20 minutes with no contact, we will assume that the appointment has been missed and we will have to reschedule your appointment. The visit might also be subject to a missed appointment fee.

PATIENT NON-DESCRIMINATION POLICY

It is the policy of Positive Touch Medicine that staff and administration treat all patients regardless of race, color, national origin, religion, sexual orientation, gender identity or expression (respective of preferred gender and pronouns), veteran status, disability, marital status, creed, or any other unlawful or discriminatory basis as prohibited by federal, state, or local law.

Discrimination or harassment by any associate of Positive Touch Medicine will not be tolerated.

____ ________________________

Signature of patient or parent/legal guardian Date signed

ELECTRONIC COMMUNICATIONS POLICY

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DISCLOSURE OF RISKS/HIPAA COMPLIANCE

Email communication is available as an alternate method of contacting your practitioner and/or the office staff. HIPAA laws allow for this method of communication so long as the patient remains aware of the possible risks of communicating electronically.

DISCLOSURE OF RISKS: the email accounts associated with Positive Touch Medicine and its practitioners are **not encrypted**. Any health information communicated via email does have a small risk of being intercepted and read by other parties. Any health information disclosed via email by the patient is transmitted at his/her own risk.

Please note that if you are concerned at all about HIPAA laws and the transmission of protected health information via email, you *can* opt out of all electronic communications (check the appropriate box below) and continue to use our secure telephone line or traditional mail to disclose any information to our practitioners or staff.

USE AND MISUSE OF ELECTRONIC COMMUNICATIONS

Electronic communications are made available to you to be able to discuss treatment plans/transmit questions to your practitioner. This is a convenience we offer to patients to help encourage the pursuit of wellness by keeping the practitioner updated so we can make the most informed decisions about your health. Please note that the practitioner is not required to respond or may respond with a recommendation to schedule an appointment.

We ask that you do not use the emails provided for requesting new prescriptions, discussing new health concerns, asking for assorted medical advice, or relaying medical emergencies. Please contact the office to schedule an appointment or speak with one of the practitioners in these cases. Patients who continually abuse email communications (e.g. send multiple emails a day, ask for assorted medical advice, or request new prescriptions) may incur a charge of $20 per email at the practitioner's discretion.

PLEASE FILL OUT AND SIGN THIS BOTTOM PORTION

I,__________________________(print your name), have read and understand the risks associated with communicating electronically. Based on the risks outlined above (please check the appropriate box):

□ **I do NOT** want to communicate electronically with Positive Touch Medicine and its practitioners.

□ **I DO** want to communicate electronically and, if necessary, I authorize the use of email to transmit the following:

- □ Appointment dates, times, scheduling, etc.
- □ Insurance inquiries, account balances, invoices and receipts
- □ Treatment plan clarifications, treatment guides
- □ Laboratory results
- □ Patient handouts
- □ Information about health status

____ ________________________

Signature of patient or parent/legal guardian | Date signed

INSURANCE QUESTIONNAIRE

Dr. Cynthia Senter, ND | Dr. Alexandra Porter, ND | Dr. Lindsey Harding, ND
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This questionnaire is to help you better understand the benefits of your insurance plan, as well as to help us to understand how best to bill your insurance. Before your first appointment, we suggest calling your insurance company and ask the following questions, to go over the extent of naturopathic coverage, deductibles, co-insurance, and co-pays. Please note that regardless of the insurance company, coverage differs greatly from plan to plan. Having a provider contracted with your insurance company does not necessarily ensure coverage of services.

Insurance Company | Plan Name: ________________________________
ID or SS# | Subscriber Name ____________________________
Group # | Subscriber DOB ______________________________

Naturopathic coverage: Does my plan include naturopathic coverage? Yes ___ NO ___

- If YES: Is Dr Cynthia Senter (NPI 108 377 9425) listed in the provider network? Yes ___ NO ___
- Dr Alexandra Porter (NPI 139 689 0331)? Yes ___ NO ___
  - If NO: Are there any out-of-network benefits? Yes___ $__________ No ___
- How many naturopathic visits am I allowed per year?_________________

Deductibles:

- What is my deductible for office visits? $______________
- What is the amount I have paid this year? $___________________
- Is the deductible for per calendar year or per the start of contract?_________________________
- Is there an office visit limit? o Yes:_______________o No

Copays and Coinsurance:

- Do I have a co-pay for office visits? Yes ___ $__________ No ___
- What percent (after my deductible has been met) do I owe? ______%
- Does that percentage for physical therapy differ from office visits/labs? Yes ___ NO ___
  - If NO, what are the different percentages?____________________

Other coverage 9uestions:

- Are physical therapy benefits included in my plan (CPTs 97112, 97035)? Yes ___ No ___(skip to next section)
- Is the % coinsurance the same as for office visits? Yes ___ No ___
- Is there a separate category of deductible for physical therapy? Yes ___ No ___(skip to next section)
- How much is the deductible for physical therapy? $_________
- What is the amount for this deductible paid this year? $_______
- Are lab fees covered 100% for preventative exams (cholesterol, CBCs, etc)? Yes ___ (skip next section) NO ___
- What category of deductible do lab fees fall under? ___________________________
- What is the amount of this deductible? $________What is the amount I have paid? $________

STATEMENT OF PRIVACY PRACTICES

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Our office is dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. The commitment of each practitioner and employee is to ensure that your health information is never compromised is a principal concept of our practice. We may from time to time amend our privacy policies and practices but we will always inform you of any changes that might affect your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and health care operations. Your health information will never be otherwise given to anyone – even family members – without your written consent. If desired, you may give us written authorization for us to disclose your information to anyone you choose, for any purpose. Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTH INFORMAITON

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), social security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

As stated above, we may disclose information if required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, or answering machines.

YOUR PATIENT RIGHTS

You have a right to request copies of your health care information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information. Signing this document signifies that you have read and understand our Statement of Privacy Practices.

____ ____________________
SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN DATE SIGNED

INFORMED CONSENT FOR TREATMENT

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I,___________________________(full name or name of parent/guardian), hereby authorize the Naturopathic Physician to perform the following specific procedure(s) as necessary to facilitate a diagnosis and treatment:

- Common diagnostic procedures: e.g., venipuncture, Pap smears, and laboratory.
- Minor office procedures: e.g., dressing a wound, ear cleansing.
- Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation of vitamins, minerals, amino acids and other nutritional or therapeutic substances.
- Botanical medicine: botanical substances (herbal medicines) may be prescribed as teas, alcoholic tinctures, capsules, tablets, cremes, plasters, or suppositories.
- Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.
- Lifestyle counseling and hygiene: diet therapy, fasting, elimination diets, promotion of wellness including recommendations for exercise, sleep, stress reductions, and balancing of work and social activities.
- Psychological counseling.
- Physical medicine, ultrasound, and bodywork.

The naturopathic doctor will and explain to my satisfaction the basic procedures of the above therapies and the risks and benefits of the care I will receive and I have been given the opportunity to ask questions about the treatment plan and procedures. I recognize certain potential risks and benefits of the procedures I am receiving, as they were described to me and as described more generally below:

- **POTENTIAL RISKS:** allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, venipuncture for diagnostic testing, and possible prescription drug interaction with prescribed natural supplements or products.
- **POTENTIAL BENEFITS:** restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
- **NOTICE TO PREGNANT WOMEN:** All female patients must inform the treating doctor if they know or suspect that they are pregnant as some of the procedures and therapies described above may present a risk to the pregnancy.
- **CONSENT:** With this knowledge, I voluntarily consent to the above procedure(s), realizing that no guarantees or warrantees have been given to me by Positive Touch Medicine or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.
- **CONFIDENTIALITY:** I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my lawful representative, or me or unless law permits or requires it. I understand that I may request to view my medical records and can request a copy of it by paying the appropriate copying fee.

I understand that a medical record will be kept for a minimum of seven years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that my practitioner will answer any questions I have, to the best of his/her ability.

I certify that I have read and fully understand this consent and the matters, which have been explained to me. I further certify that I have full authority and accept full responsibility to execute this consent for and on behalf of the patient named below and that I am signing freely and voluntarily.

____ ______________________

SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN DATE SIGNED

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Health History Profile

Name:________________________________Date of Birth:____/____/______Age:_______Sex:________

What other healthcare are you currently receiving? ____

____

____

Previous physician (s) and their practice: ____

____

How did you hear about Positive Touch Medicine? □ Referral by physician: ___________________________
□ Referral by friend/relative: ________________________
□ Website/Facebook/Yelp/other: ______________________

NOTE TO PATIENTS: *Naturopathic, holistic, and preventative healthcare are only effective when the physician has a completely rounded understanding of the patient physicaly, mentally, and emotionaly. Please complete this questionnaire as thoroughly as possible. Thank you.*

What are your present health concerns, listed in order of importance? __________________________________

____

____

How was your health as a child? □ Poor □ Decent □ Good □ Very good

What was your place of birth? ____

What childhood illnesses did you have? ____

Have you ever had a blood transfusion? □ No □ Yes. List date(s): ____________________________________

Have you ever been hospitalized? □ No □ Yes: list the year(s) and reason(s): ___________________________

____

____

Have you ever had surgery? □ No □ Yes: list the year and type of surgery. ______________________________

____

Other serious injuries or illnesses: ____

____

Do you have any allergies? □ No □ Yes: 1.________________________________Severity: 1 2 3 4 5 6 7 8 9 10
2.________________________________Severity: 1 2 3 4 5 6 7 8 9 10
3.________________________________Severity: 1 2 3 4 5 6 7 8 9 10

HEALTH HABITS Check which substances you use and describe the frequency/amount of use.

□ Caffeine: ____

□ Tobacco: ____

□ Alcohol: ____

□ Drugs: ____

MEDICATION USE Please list all supplements, prescription and non-prescription drugs used and dosages:

____

____

____

DIET, SLEEP, AND EXERCISE

Are you satisfied with your diet as it is now? □ Yes □ No Describe any dietary restrictions or regimens:

____

____

Do you sleep well? □ Yes □ No Average hours of sleep per night: ____________________

Do you exercise regularly? □ Yes □ No Avg. hrs/wk:_________Type? ____________________

OCCUPATIONAL CONCERNS Occupation: ____

Please check the hazards you are exposed to at work: □ Stress: ___________________________________

□ Hazardous substances :____________________□ Heavy lifting: ___________________

□ Other (please explain): ____

FAMILY HISTORY Fill in the blanks below or check all that apply to your family history

	Mother	Father	Sibling(s)	Spouse	Children
Age (if living)	______	______	______	______	______
Age at death	______	______	______	______	______
Heart disease	□	□	□	□	□
Diabetes	□	□	□	□	□
Chemical dependency	□	□	□	□	□
Mental illness	□	□	□	□	□
Asthma, hay fever, hives	□	□	□	□	□
Anemia	□	□	□	□	□
Kidney disease	□	□	□	□	□
Glaucoma	□	□	□	□	□
Tuberculosis	□	□	□	□	□
Genetic disorders	______	______	______	______	______
Other (please explain)	______	______	______	______	______

GENERAL INFORMATION

Height:______ Weight:___________ Highest weight:________ Weight 1 year ago: _____________

REVIEW OF SYSTEMS Please review each system and symptoms listed below. (Prev. = previously)

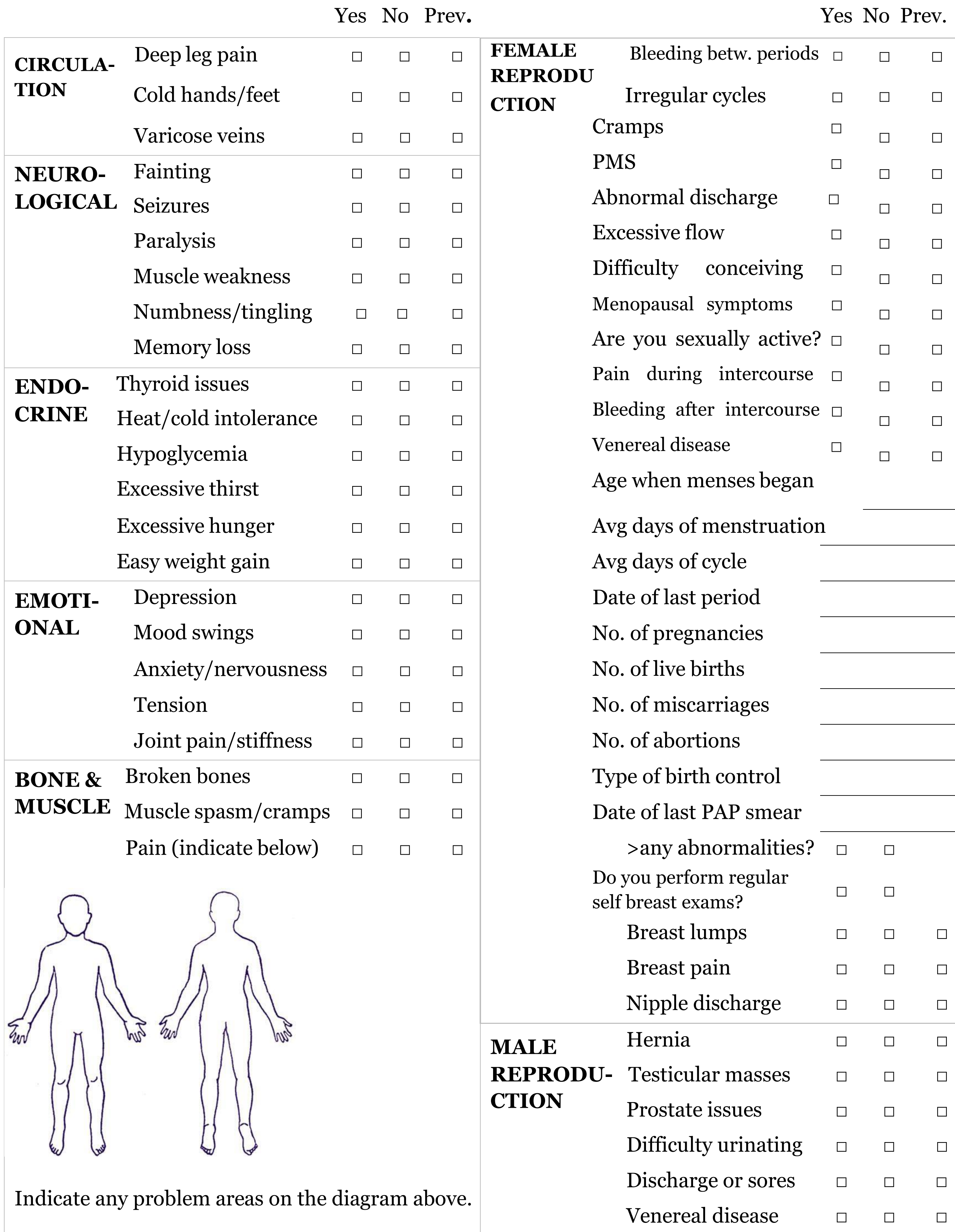
Are you experiencing these symptoms? Check the correct box or fill in the blanks below.

		Yes	No	Prev.
SKIN	Rashes	☐	☐	☐
	Inflammation	☐	☐	☐
	Infection	☐	☐	☐
	Abnormal growths	☐	☐	☐
	Change in hair/nails	☐	☐	☐
HEAD	Frequent headaches	☐	☐	☐
	Migraine	☐	☐	☐
	Head injury	☐	☐	☐
EYES	Impaired vision	☐	☐	☐
	Eye pain	☐	☐	☐
	Double vision	☐	☐	☐
EARS	Impaired hearing	☐	☐	☐
	Ringing	☐	☐	☐
	Earache or itch	☐	☐	☐
	Dizziness	☐	☐	☐
NOSE	Frequent colds	☐	☐	☐
	Nosebleeds	☐	☐	☐
	Stuffiness	☐	☐	☐
	Sinus issues	☐	☐	☐
	Post nasal drip	☐	☐	☐
THROAT & MOUTH	Frequent sore throat	☐	☐	☐
	Sore tongue	☐	☐	☐
	Mouth/lip sores	☐	☐	☐
	Gum disease	☐	☐	☐
	Hoarseness	☐	☐	☐
	Dental issues	☐	☐	☐
URINARY	Pain on urination	☐	☐	☐
	Increased frequency	☐	☐	☐
	....at night	☐	☐	☐
	Inability to hold	☐	☐	☐
	Bladder infection	☐	☐	☐

		Yes	No	Prev.
BLOOD	Anemia	☐	☐	☐
	Easy bleeding/bruising	☐	☐	☐
LUNGS	Chronic cough	☐	☐	☐
	Spitting up blood	☐	☐	☐
	Wheezing	☐	☐	☐
	Difficulty breathing	☐	☐	☐
	....when lying down	☐	☐	☐
	....at night	☐	☐	☐
	Tuberculosis	☐	☐	☐
HEART	Heart disease	☐	☐	☐
	High blood pressure	☐	☐	☐
	Rheumatic fever	☐	☐	☐
	Chest pain	☐	☐	☐
	Swelling in ankles	☐	☐	☐
	Palpitations, fluttering	☐	☐	☐
DIGESTION	Trouble swallowing	☐	☐	☐
	Heartburn	☐	☐	☐
	Stomach pain	☐	☐	☐
	Change in thirst	☐	☐	☐
	Change in appetite	☐	☐	☐
	Nausea	☐	☐	☐
	Vomiting	☐	☐	☐
	Freq of bowel movements: ____________			
	Change in frequency	☐	☐	☐
	Loose stools	☐	☐	☐
	Blood in stools	☐	☐	☐
	Belching, gas	☐	☐	☐
	Liver/gall bladder dz.	☐	☐	☐
	Hemorrhoids	☐	☐	☐
OTHER	Fatigue	☐	☐	☐
	Vertigo, dizziness	☐	☐	☐

Are you experiencing these symptoms? Check the correct box and fill in the blanks below.

		Yes	No	Prev.
CIRCULA-TION	Deep leg pain	☐	☐	☐
	Cold hands/feet	☐	☐	☐
	Varicose veins	☐	☐	☐
NEURO-LOGICAL	Fainting	☐	☐	☐
	Seizures	☐	☐	☐
	Paralysis	☐	☐	☐
	Muscle weakness	☐	☐	☐
	Numbness/tingling	☐	☐	☐
	Memory loss	☐	☐	☐
ENDO-CRINE	Thyroid issues	☐	☐	☐
	Heat/cold intolerance	☐	☐	☐
	Hypoglycemia	☐	☐	☐
	Excessive thirst	☐	☐	☐
	Excessive hunger	☐	☐	☐
	Easy weight gain	☐	☐	☐
EMOTI-ONAL	Depression	☐	☐	☐
	Mood swings	☐	☐	☐
	Anxiety/nervousness	☐	☐	☐
	Tension	☐	☐	☐
	Joint pain/stiffness	☐	☐	☐
BONE & MUSCLE	Broken bones	☐	☐	☐
	Muscle spasm/cramps	☐	☐	☐
	Pain (indicate below)	☐	☐	☐



Indicate any problem areas on the diagram above.

		Yes	No	Prev.
FEMALE REPRODUCTION	Bleeding betw. periods	☐	☐	☐
	Irregular cycles	☐	☐	☐
	Cramps	☐	☐	☐
	PMS	☐	☐	☐
	Abnormal discharge	☐	☐	☐
	Excessive flow	☐	☐	☐
	Difficulty conceiving	☐	☐	☐
	Menopausal symptoms	☐	☐	☐
	Are you sexually active?	☐	☐	☐
	Pain during intercourse	☐	☐	☐
	Bleeding after intercourse	☐	☐	☐
	Venereal disease	☐	☐	☐
	Age when menses began	______		
	Avg days of menstruation	______		
	Avg days of cycle	______		
	Date of last period	______		
	No. of pregnancies	______		
	No. of live births	______		
	No. of miscarriages	______		
	No. of abortions	______		
	Type of birth control	______		
	Date of last PAP smear	______		
	>any abnormalities?	☐	☐	
	Do you perform regular self breast exams?	☐	☐	
	Breast lumps	☐	☐	☐
	Breast pain	☐	☐	☐
	Nipple discharge	☐	☐	☐
MALE REPRODU-CTION	Hernia	☐	☐	☐
	Testicular masses	☐	☐	☐
	Prostate issues	☐	☐	☐
	Difficulty urinating	☐	☐	☐
	Discharge or sores	☐	☐	☐
	Venereal disease	☐	☐	☐

OPTIONAL QUESTION: What is your sexual orientation? ______________________________

Ayurvedic Constitution Quiz

Dr. Cynthia Senter N.D.
Dr. Alexandra Porter N.D
Dr. Lindsey Harding N.D.
P (206) 547-5510 F (206)547-5517
929 N. 130th Suite 6,
Seattle, WA 98133

Determine your dominant ayurvedic psychophysiological (mind-body) constitutional type: Vata, Pitta or Kapha. The following simple test will give you a fairly good idea of the levels of your doshas. We have to remember that everyone has all three doshas, but in varying degrees. After reading each description, mark Oto 7 in front of the question. Note that values 2 and 5 are not assigned at all (don't use them).

0, 1 = Does not apply 3, 4 = Applies sometimes 6, 7 = Applies most of the time

Evaluating My Vata

Physical Attributes:

1 .My physique is thin - I don't gain weight easily.
2.I am quick and active.
3.My skin is usually dry, more so in winter.
4.My hands and feet are usually cold.
5. My energy fluctuates and comes in bursts.
6.I usually develop gas or constipation.
7. I usually have difficulty falling asleep or having a sound night's sleep.
8. I am uncomfortable in cold weather.

Mental, Emotional, and Behavioral Attributes:

9. My nature is lively and enthusiastic.
10.I have difficulty memorizing things and remembering them later.
11.It is easy for me to learn new things quickly, but I also forget quickly.
12.I am not good at making decisions.
13.I am anxious or worrisome by nature.
14.People think I'm talkative and that I talk quickly.
15.I am usually emotional by nature and my moods fluctuate.
16.My mind is restless, but also imaginative.
17.I have irregular eating and sleeping habits.

Total Vata:

Evaluating My Pitta

Physical Attributes:

1.My hair is fine, straight, light, blonde, red, graying early, or balding.
2.I don't tolerate hot weather.
3.I sweat easily.
4.I can't tolerate delaying or skipping a meal.
5.My appetite is very good and I can eat big meals.
6.My bowel movements are regular. I might have occasional loose stool but not much constipation.
7.I like cold drinks and such foods as ice cream.
8.I often feel hot.
9.Spicy, hot foods upset my stomach.

Mental, Emotional, and Behavioral Attributes:

10. I consider myself efficient.
11. I try to be organized and accurate.
12. I have a strong will and my friends think I am stubborn.
13. I am impatient by nature.
14. I tend to become irritable or angry quite easily.
15. I try to be meticulous and I am a perfectionist by nature.
16. I get angry easily, but I don't hold a grudge.
17. I am usually critical of myself and others.

Total Pitta:

Evaluating My Kapha

Physical attributes:

1. It is easy for me to gain weight but it is difficult to lose.
2. Skipping meals is easy for me and doesn't cause any problems.
3. I tend to have congestion, mucus, or sinus problems.
4. I'm a sound sleeper.
5. I have thick, oily, dark, wavy hair.
6. My skin is smooth and soft with an almost pale complexion.
7. My body frame is large and solid with a heavy bone structure.
8. My digestion is slow, so I feel full after eating.
9. I have a steady energy level with good endurance and strong stamina.
10. I'm sensitive to cool and damp weather.

Mental, Emotional, and Behavioral Attributes:

11. I tend to be slow, methodical, and relaxed.
12. I need to sleep a minimum of eight hours to feel well the next morning.
13. By nature I am calm and composed. I don't get angry easily.
14. I am not a quick learner but I am good at remembering things and remembering them later.
15. Many people consider me affectionate, forgiving, and peaceful.
16. I usually oversleep and have difficulty waking in the morning.
17. I am very reluctant to take on new responsibilities.

Total Kapha:

I am_____________first,_______________second, and_____________third.