Application for Services

Please call or arrive on time for your appointment.

My practitioner's name is **Jill Curtis**. My practitioner will provide an educational Ayurvedic consultation in order to:

- Determine my mind-body constitution.
- Identify and assess any imbalances that may exist.
- Provide information and guidance relevant to helping me nourish, stimulate or balance vital energy.
- Develop a plan with me for diet and lifestyle changes that may improve my general health and wellness.

I agree to:

- Study the information provided.
- Participate in the development of my health and wellness plan.
- Implement my health and wellness plan according to my ability.
- Notify my primary care provider, if under their care, of my intention to begin a new health & wellness plan.
- Discontinue any or all of the health and wellness plan elements if any discomfort occurs and notify my consultant and primary care provider.

Please email **jill.curtis@fivepointsayurveda.com** or send a text to **402-689-5704** with the following documents:

- Application for Services (Page 1)
- Health Information and History (Pages 2-5)
- Daily Schedule / Routine (Page 6)
- 3-day Food Journal (Page 7 – include more pages if needed)
- Photos (Page 8 – include more pages if needed or send via email)

We recommend you bring a notebook and pen to your appointment to take notes.

Practitioner Client Relationship

If your practitioner sees you in public, he/she usually won't acknowledge you until you acknowledge him/her first. This is to maintain your confidentiality. To keep your relationship professional, please refrain from asking personal questions about your practitioner.

In addition to the symptoms you indicate below, we'll be discussing the state of your digestion, elimination, sleep, energy, and the systems of the body during our visit.

Clients are given lifestyle, diet, and other recommendations. **I understand that this is an educational Ayurvedic consultation for the purpose of helping me to improve my own health and wellness. I understand this does not constitute medical diagnosis or medical treatment and is not a substitute for medical care. It is not an agreement for ongoing care.**

Client Signature: _____ Date: _____

Health Information and History

Client Name:	**Home Address:**
Email:	**City/State/Zip**:
Phone Number:	**Occupation**:
Date of Birth:	**Marital Status:**
Family Physician:	**Last Physical Exam**:
Height:	**Weight:**

Objectives/Goals - Circle the items that reflect your main objectives/goals and/or add other objectives/goals.
Please note that Ayurvedic Consultations do not include medical diagnosis and treatments. If you are concerned about a medical condition or a latent or potential medical condition you should see a medical doctor.

☐ I want an alternative approach to allopathic medicine for managing illness and disease.
☐ I want to improve my general health and wellness and reduce my vulnerability to illness and disease.
☐ I want to improve my lifestyle and dietary practices to improve my health.
☐ I want to change my habits and behavioral patterns to improve my relationships with others.
☐ I want to manage stress, tension, and worry to attain a more stable emotional nature.
☐ Other:

Primary concerns (in order of importance & how long they have troubled you)

How would you be able to live your life differently if these concerns were removed?

Personal History – Do you or your family members have a history of: (Check appropriate ones)

Symptom	Me	Family	Symptom	Me	Family
Allergies to Food/Drugs/Mold	☐	☐	Heart Murmur, Palpitations	☐	☐
Anemia	☐	☐	Hepatitis A / B / Other	☐	☐
Arthritis	☐	☐	HIV Exposure	☐	☐
Asthma, Pneumonia, TB	☐	☐	IBS, Colitis, Crohn's, Celiac, etc.	☐	☐
Autoimmune Disease	☐	☐	Implant, Prosthesis	☐	☐
Blood Pressure (High/Low)	☐	☐	Kidney or Bladder Disease / Infection	☐	☐
Cancer / Chemotherapy / Radiation	☐	☐	Mononucleosis, Jaundice, Gallstone	☐	☐
Chest Pain/Angina	☐	☐	Pain/Ringing in the Ear	☐	☐
Cholesterol / Triglycerides (High)	☐	☐	Parasites / Tropical / Chronic Infection	☐	☐
Contact Lenses / Prescription Glasses	☐	☐	Popping, Clicking, Locking of the Jaw	☐	☐
Dental Treatment Complications	☐	☐	Prolonged Bleeding When Cut	☐	☐
Diabetes	☐	☐	Psychiatric Treatment	☐	☐
Dizziness, Fainting	☐	☐	Rheumatic / High Fever	☐	☐
Epilepsy, Convulsions, Seizures	☐	☐	Shortness of Breath	☐	☐
Feet or Ankles, Swelling	☐	☐	Stroke, Cerebro-Vascular Accident	☐	☐
Glaucoma, Eye Surgery	☐	☐	Thyroid Disease or Medication	☐	☐
Headaches/Migraines	☐	☐	Ulcers, Intestinal Bleeding	☐	☐
Heart Attack / Disease / Surgery	☐	☐	Venereal Diseases	☐	☐

Medical History (Include pertinent medical diagnoses/interventions you have had including illnesses, surgeries, diseases, injuries, trauma, emotional stresses, mental stresses, lifestyle conditions, addictions, alcohol, drug use, changes of weight, or anything else to help us clearly understand your health condition)

Family Medical History (mother, father, siblings)

What prescription drugs are you taking?
(Including birth control)

What non-prescriptions drugs, supplements, or recreational drugs are you taking or have taken?
(Including alcohol, tobacco, caffeine, marijuana)

Females:

Age of first menstrual period:	**Last menstrual period**:
Birth control pills: Y ☐ N ☐	**IUD**: Y ☐ N ☐
Pregnant currently: Y ☐ N ☐	**Number/Age of Children**:
Menopause: Y ☐ N ☐	**If menopause, age of**:
Length of menstrual cycle:	**Flow**: Heavy ☐ Moderate ☐ Light ☐
Color of blood:	**Blood Clots**: Y ☐ N ☐
Pain/symptoms during period:	**Pain/symptoms before period** (PMS):
Other female symptoms:	

Please check any recent symptoms within the last few months:

☐	Constipation	☐	Diarrhea/loose stools	☐	Thick/oily/sluggish stools	☐	Sticky/sinking stools
☐	Gas	☐	Nausea/vomiting	☐	Cold/cough /congestion	☐	Foul stool odor
☐	Bloating	☐	Burning/sharp pain in GI	☐	Food/respiratory allergies	☐	Coating on tongue
☐	Dry skin/lips /hair/nails	☐	Heartburn	☐	Edema	☐	Bad breath
☐	Dry cough	☐	Indigestion	☐	Feelings of heaviness	☐	Low fever
☐	Muscle pain/twitching/ cramping/weakness	☐	Bleeding (gums, hemorrhoids, etc.)	☐	Dull/vague pain	☐	Tired/sluggish after eating
☐	Dehydration	☐	Tenderness to touch	☐	Runny nose	☐	Malaise
☐	Ringing ears (tinnitus)	☐	Gout	☐	High cholesterol	☐	Lack of energy /stagnation
☐	Light-headed	☐	Bruises easily	☐	Swollen lymph glands	☐	Ache at the roots of hair
☐	Receding gums	☐	Mouth sores	☐	Fungal infections	☐	General aches/pains
☐	Heart palpitations	☐	Hair loss or early graying	☐	Fibrocystic lumps /tumors	☐	Mental lethargy/confusion
☐	Hemorrhoids (non-bleeding)	☐	Migraine headaches	☐	Gallstones	☐	Foul body odor
☐	Restlessness (day or night)	☐	Red or itchy eyes	☐	Low libido	☐	Thick saliva/drooling during sleep
☐	Excess thirst	☐	Frequent infections	☐	Excess urination	☐	Brain fog
☐	Brittle hair/teeth/nails	☐	Allergies/hay fever	☐	Bone spurs	☐	Candida/yeast infections
☐	Varicose veins	☐	Rashes/hives/boils /acne/eczema/psoriasis	☐	Slow metabolism	☐	Sexual debility
☐	Cold hands/feet	☐	Hot flashes/excess body heat	☐	Cold/clammy hands	☐	Low grade fever
☐	Joint pain/cracking /popping	☐	Inflamed/hot joints	☐	Joint swelling /stiffness	☐	Indecisiveness
☐	Insomnia/ difficulty falling/staying asleep	☐	Interrupted sleep	☐	Excess sleep/daytime naps	☐	Perverse taste in mouth
☐	Variable appetite	☐	Excess/sharp hunger	☐	Excess ear wax/nasal crust	☐	Lack of taste/appetite
☐	Hypersensitivity to noise	☐	Redness of skin	☐	Excess oily skin	☐	Unresolved emotions
☐	Difficulty sweating	☐	Excess sweating	☐	Cold/clammy sweat	☐	
☐	Difficulty gaining weight	☐	Tendonitis/bursitis	☐	Increasing weight	☐	
☐	Forgetfulness/poor memory	☐	Hiccough	☐	Hypertension	☐	
☐	Inability to concentrate	☐	Herpes/shingles	☐	Glaucoma	☐	
☐	Racing mind	☐	Irritability	☐	Feelings of laziness	☐	
☐	Worry/fear/anxiety /insecurity	☐	Anger/hate/envy /judgment/ jealousy	☐	Depression/attachment /unforgiving/greed	☐	

Daily Schedule / Routine

Describe your activities from the time you wake up until you go to sleep. **Include approximate times.** (Such as: eating, drinking, sleeping, urinating, defecating, exercise, work, play…).

Morning	
Typical activities: Routines on waking:	
Afternoon	
Typical activities	
Evening	
Typical activities: Routines before bed:	
How does this routine change on days off (weekends vs work week)?	

3-Day Food Journal

Please write down all food you have eaten and drank for the last three days. Add additional pages if needed.

Day 1		
Breakfast:	Time:	
	Food:	
Lunch:	Time:	
	Food:	
Dinner:	Time:	
	Food:	
Snacks:	Time:	
	Food:	
Beverages:	Time:	
	Drink:	
Day 2		
Breakfast:	Time:	
	Food:	
Lunch:	Time:	
	Food:	
Dinner:	Time:	
	Food:	
Snacks:	Time:	
	Food:	
Beverages:	Time:	
	Drink:	
Day 3		
Breakfast:	Time:	
	Food:	
Lunch:	Time:	
	Food:	
Dinner:	Time:	
	Food:	
Snacks:	Time:	
	Food:	
Beverages:	Time:	
	Drink:	

Photos:

Please insert below or email the following photos before your first phone appointment, and at least once a year afterwards. Tongue photos should be sent every follow up.

- Full length photo from the front
- Full length profile from the side
- Close up of face
- Close up of both hands, palms downward
- Entire top of tongue, including back area
- Close up of eyes looking to the right & left
- Full length childhood photo before the age of 5