Date _____

Name _____

Address _____

City, Zip _____

Home phone _____ Work phone _____

Age _____ Occupation _____

Marital Status _____ E-Mail _____

Health History

Chronic Illness _____

Physical Limitations _____

History of disease in family _____

Any Surgery _____

Taking Medication _____

List major stress factors _____

Need help controlling alcohol, drugs, or cigarettes _____

Any eating disorders _____

Exercise habits _____

Any metaphysical background _____

Interested in food philosophies for cleansing or weight _____

_____% Meat, fish or eggs _____% Fruit _____% Vegetables

_____% Fast or junk food _____% Whole natural food

Use Caffeine _____ Sugar _____ White flour _____

List Priori-
ties:_____
__

_____

_____

_____

Yoga/Ayurveda Client Statement

I hereby attest to the following:

1. I fully understand that Yogi Baba Prem Tom Beal is not a medical doctor or practitioner, does not diagnose or treat disease. I fully understand that I am not here for medical diagnostic or treatment procedures.

2. The services performed by Yogi Baba Prem Tom Beal , whether in person or by mail, or by phone, are at all times restricted to consultation on the subject of yoga spiritual matters intended for the maintenance of the best possible state of yoga health and do not involve the diagnosing, treatment, or prescribing of remedies for the treatment of disease.

3. I understand that it is my constitutional right to decide how I wish to care for the health of my body. (Yogi Baba Prem Tom Beal has not suggested that I cease current medical care I am receiving, be it drug therapy, x-ray treatments, chemotherapy, surgery, or any other medical procedures that my doctor deems necessary to my health. If I choose to not follow recommendations made by my medical doctor, I understand that such a decision is my responsibility and will not hold Yogi Baba Prem Tom Beal responsible for any consequences of such a decision.

4. I am here, on this and any subsequent visit, solely on my own behalf and not as an agent for federal, state, or local agencies on a mission of entrapment or investigation.

5. I understand all information provided by Yogi Baba Prem Tom Beal is based on historical and traditional uses pertaining to yoga and Ayurveda. This information is not intended as a diagnosis or prescription. It is intended solely for education purpose, as to the historical and traditional uses.

6. I understand this statement shall apply to all workshops, classes, phone conversations, and private sessions conducted by Yogi Baba Prem Tom Beal and/or Universal Yoga Inc.

Date: _____

Signed: _____

Print Name: _____

Naadi Vijnyaanam

	Vata	Pitta	Kapha	Notes
Gati	Sarpa	Manduuka	Hamsa	
Vega	80-95	70-80	50-60	
Taala	Irr.	Reg.	Reg	
Bala	+Low	+++High	++Moderate	
Aadruti	Low	High	Moderate	
Tapamaana	Cold	Hot	Warm to cool	
Kaathinya	Rough/Hard	Elastic/Flexible	Soft/Thickening	

Systole_____

Diastole_____

PP _____

Prakruti Jup. _____ Sat. _____ Sun _____

Vikruti Jup. _____ Sat. _____ Sun _____

Male side_____ Female side _____

Health History

Name _____ Date _____/____/_____

Sex M or F Birth date _____/_____/_____ Age _____ Height _____ Weight _____

Present Health Problems	Leave Blank
#1 Problem/Symptoms:_____ _____ _____ Date Symptoms Began: _____ Past Treatments/Medications: _____ _____ #2 Problem/Symptoms:_____ _____ _____ Date Symptoms Began: _____ Past Treatments/Medications: _____ _____ #3 Problem/Symptoms:_____ _____ _____ Date Symptoms Began: _____ Past Treatments/Medications: _____ _____	

Past Health History

Age at Onset	List your past major illnesses, injuries, and surgeries.
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(For women) List your history of pregnancies, deliveries, abortions—if any, contraceptive usage.
Also indicate the length of your menstrual cycle.

_____

_____

_____

Family Health History

Relation List major illnesses and causes of death

Mother:_____

Father: _____

Sister/Brother (s): _____

_____

Maternal Grandmother/Grandfather: _____

_____

Paternal Grandmother/Grandfather:_____

_____

Environmental Stresses and Contaminants.

Check off those items which apply to you on a constant or frequent basis.

_____ Sit or stand in a slumped, hunched over or unerect position.
_____ Sit on metal chairs for a long period of time.
_____ Stand on bare concrete floors for long periods of time.
_____ Underwear made mainly of synthetic fabrics.
_____ Outerwear made mainly of synthetic fabrics.
_____ Nightwear made mainly of synthetic fabrics.
_____ Hats, wigs or hairpieces made mainly of synthetic fabrics.
_____ Bedding sheets or blankets made mainly of synthetic fabrics.
_____ Use an electric blanket.
_____ Wear eyewear with metallic frames.
_____ Wear sunglasses nearly all the time outdoors.
_____ Wear high heeled shoes.
_____ Wear a battery-powered wrist watch.
_____ Wear partial dentures which cross the midline of the body.
_____ Have mercury amalgam fillings.
_____ Use perfumes, deodorants, shampoos, conditioners, dyes, permanent solutions, soaps, mouth washes, toothpaste's made of synthetic chemicals.
_____ Live or work in an especially noisy environment.
_____ Listen to rock music or jazz.
_____ Watch television for long periods of time (lover an hour.)
_____ Work or sit under fluorescent lighting for long periods of time.
_____ Work in front of a video console monitor for long periods of time.
_____ Cook at a gas stove.
_____ Use a microwave oven.
_____ Use aluminum cookware, utensils or packaging foil or baking powders.
_____ Have had dental/medical X-rays or operate an X-ray machine.
_____ Subject to irritating chemical fumes/agents or dust particles.
_____ Work or live indoors where the rooms are saturated with tobacco smoke.
_____ Work or travel in areas saturated with auto exhaust fumes.
_____ Work or live near high-powered electrical line or micro-wave transmitters.

Body System Appraisal

Check off those items below which apply to you on a chronic or recurrent basis at the present time or within the past year.

1 Head, ears, eyes, nose and throat

_____ Migraine headaches
_____ Headaches
_____ Dizziness
_____ Fainting spells
_____ Ear aches, discharges
_____ Hearing loss
_____ Ringing in the ears
_____ Pain/soreness in eyes
_____ Deteriorating vision
_____ Cataracts
_____ Glaucoma
_____ Thinning/loss of hair.

_____ Nose colds
  _____ Nasal/sinus congestion
  _____ Nasal discharges
  _____ Hay fever type allergies
  _____ Nose bleeding
  _____ Gums bleeding
  _____ Gums receding
  _____ Numerous dental cavities
_____ Wear dentures
  _____ Oral infections.
  _____ mouth/lip ulcers or lesions

2. Respiratory System

_____ Shortness of breath w/ exertion
_____ Wheezing
_____ Painful breathing
_____ Persistent cough

_____ Frequent chest colds
_____ Lung congestion
_____ Coughing up blood
_____ Coughing up mucous

3. Cardiovascular system and Lymph system.

_____ Tension/pain behind breastbone
_____ Fast heart beat
_____ Irregular heart beat
_____ Varicose veins

_____ Leg pain with exercise
_____ Hand/feet become numb easily
_____ Painful hands/feet due to coldness
_____ Lymph node swelling

4. Musculo-Skeletal System

_____ Swelling pain in joints
_____ Limitations on joint motion
_____ Muscle weakness/atrophy

_____ Muscle/bone deformities
_____ Muscle/bone pains in back or neck
_____ Muscle/bone pains elsewhere

5. Nerologic System

_____ Loss of taste, smell or touch
_____ Tingling sensations
_____ Tremors in limbs
_____ Muscle/limb coordination problem
_____ Difficulty in remembering
_____ Difficulty in thinking clearly

6. Urinary System

_____ Loss of control of urination
_____ Painful urination
_____ Urine retention, dribbling
_____ Frequent daytime urination
_____ Blood in urine
_____ Pain in kidney/groin area
_____ Frequent kidney/bladder infections
_____ Urine is odorous
_____ Color of urine is pale yellow
_____ color of urine is dark yellow

7. Reproductive System

(**Female System)**

_____ Premenstrual tension
_____ Menstruation prolonged
_____ Menses too frequent
_____ Menses scanty or missed
_____ Depression at menstruation
_____ Menopausal hot flashes
_____ Swelling, pain, lumps in breasts
_____ Pain on ovaries
_____ Abnormal vaginal discharges
_____ Frequent vaginal infections
_____ Genital ulcers or lesions
_____ Pain on intercourse
_____ Reduced or minimal sexual drive

(Male System)

_____ Prostate gland swollen, painful
_____ Impotence problems
_____ Abnormal discharges from penis
_____ Genital ulcers or lesions
_____ Pain on intercourse
_____ Reduced or minimal sexual drive
_____ Excessive Sexual drive

8. Gastro-Intestinal System

_____ Heaviness/bloating after eating
_____ Frequent indigestion
_____ Pain/burning in stomach area
_____ Gallbladder discomfort
_____ Diarrhea
_____ Less than 2 bowel movements daily
_____ Difficult/painful bowel movements
_____ Hemorrhoids
_____ Excessive intestinal gas
_____ Blood in stools
_____ Stools are odorous
_____ Stools are clay color [ ] brown [ ]
_____ Stools are loose [ ], soft [ ], hard [ ]
_____ Stools float [ ], sink [ ]

Health Status/Habits

1. Energy Level
Rate your basic energy level on a scale of 1-10 (optimum) _____

2. Overall Health
Rate your overall health on a scale of 1-10 (optimum) _____

3. Sleep
Rate your overall health on a scale of 1-10 (optimum) _____
How many hours of daytime sleep do you usually get with naps _____
Is your sleep position on your : Left side [ ] Right side [ ] Back [ ] Stomach [ ]
Is your sleep usually: Sound [ ] Interrupted [ ]
Do you usually wake up refreshed in the morning? Yes _____ No _____

4. Bodyweight

How much did you weight at 21 _____
How much more [ ] or less [ ] do you weigh now than at age 21 _____
How much weight have you gained [ ] lost [ ] in the past year _____
Do you feel that your are presently underweight? Yes ____ No _____
Do you feel that your ae presently overweight? Yes ____ No _____
Are you satisfied with your present body tone and shape? Yes ____ No _____

5. Drug Allergies

List below the name of the drugs that you have known allergic responses to:

_____

_____

_____

6. Pharmaceutical Medications

List below the pharmaceutical drugs (prescription and non-prescription) which you regularly take and explain what condition they are taken for:

Drug	Reason Taken
_____	_____
_____	_____
_____	_____
_____	_____

In each category circle the trait that most correctly reflects the last 10 years of your life. If you are unsure about a category, place a dot next to the category and ask during your session.

Ayurveda Dosha Questionnaire

Catagories	Vata	Pitta	Kapha
Height	Tall or Short	Medium	Short or Tall
Frame	Thin, Bony	Moderate-good muscles	Large, well developed
Weight	Low, hard to gain weight	Moderate	Heavy, hard to lose weight
Skin Luster	Dull	Ruddy or lustrous	White or pale
Skin Texture	Dry, rough, thin	Warm, Oily	Cold, damp, thick
Eyes	Small, nervous	Piercing, intense	Large, White
Hair	Dry, Thin	Thin, Oily	Thick, Oily, Wavy
Teeth	Crooked, poorly formed	Moderate, bleeding gums	Large, well formed
Nails	Rough, brittle	Soft, pink	Soft white or thick
Joints	Stiff, Crack easily	Loose	Firm Large
Circulation	Poor, variable	Good	Moderate
Appetite	Variable, nervous eater	High, excessive	Moderate, but constant
Thirst	Low, scanty	High	Moderate
Sweating	Scanty	Profuse but declines	Profuse slow to start
Stool	Hard or dry (small)	Soft, loose (medium)	Large well formed
Urination	Scanty	Profuse, yellow	Moderate, clear
Sensitive to...	Cold, dryness, wind	Heat, sunlight, fire	Cold, damp
Immune function	Low, variable	moderate	High
Disease tendency	Pain	Fever, inflammation	Congestion, edema
Disease type	nervousness	Blood, liver	Mucous, lungs
Activity	High, restless	moderate	Low, moves slowly
Endurance	Poor, easily exhausted	Moderate (sprinter)	High
Sleep	Poor, easily disturbed	Variable	Excess
Dreams	Frequent	Moderate	Infrequent
Memory	Quick, but absent minded	clear	Slwo but steady
Speech	Fast, frequent	Sharp, cutting	slow
Temperament	Nervous, Changeable	Motivated	Content, conservative
Positive Emotions	Adaptability	Courage	Love
Negative emotions	Fear	Anger	Attachment
Total	Vatta _____	Pitta _____	Kapha _____

Source: Ayurveda & the Mind, Dr. David Frawley, Lotus books. Used with Permission of Author

Manas Constitution Chart—Guna Evaluation

Diet	Vegetarian	Some meat	Heavy meat
Drugs, Alcohol, Stimulants	Never	Ocassionally	Frequently
Sensory Impression	Calm, pure	Mixed	Disturbed
Need for Sleep	Little	Moderate	High
Sexual Activity	Low	Moderate	High
Control of Senses	Good	Moderate	Weak
Speech	Calm & Peaceful	Agitated	Dull
Cleanliness	High	Moderate	Low
Work	Selfless	For Personal Goals	Lazy
Anger	Rarely	Sometimes	Frequently
Fear	Rarely	Sometimes	Frequently
Desire	Little	Some	Much
Pride	Modest	Some Ego	Vain
Depression	Never	Sometimes	Frequently
Love	Universal	Personal	Lacking in love
Violent Behavior	Never	Sometimes	Frequently
Attachment to Money	Little	Some	A lot
Contentment	Usually	Partly	Never
Forgiveness	Forgives easily	With effort	Holds long term grudges
Concentration	Good	Moderate	Poor
Memory	Good	Moderate	Poor
Will Power	Strong	Variable	Weak
Truthfulness	Always	Most of the time	Rarely
Honesty	Always	Most of the time	Rarely
Peace of Mind	Generally	Partly	Rarely
Creativity	High	Moderate	Low
Spiritual Study	Daily	Occasionally	Never
Mantra or Prayer	Daily	Occasionally	Never
Meditation	Daily	Occasionally	Never
Service to others	Much	Some	None
Total:	Sattva _____	Rajas _____	Tamas _____

Source: Ayurveda & the Mind, Dr. David Frawley, Lotus books Used with Permission of Author.

Organ Energy Level

CO	GB	PER
LU	LI	TRI
SI	ST	BL
HT	SL	KD

CO	GB	PER
LU	LI	TRI
SI	ST	BL
HT	SL	KD

CO	GB	PER
LU	LI	TRI
SI	ST	BL
HT	SL	KD

CO	GB	PER
LU	LI	TRI
SI	ST	BL
HT	SL	KD

CO	GB	PER
LU	LI	TRI
SI	ST	BL
HT	SL	KD

Historical Key...
CO—Triphala 1/2. Contr use PSY.HUSK
LU—Pipali 1/8 2x
GB—Trikatu 1/8 2x w/me
LI—1/8 2x
PER—Jatamansi 1/4-1/2 2x's
TRI— Cardamon 1/8, Cinnamon 1/2, Ginger 1/4 Inch as tea w. honey
SI—Chitrak—1/8 2x
HE—Arjuna 1/8-1/2 2x
ST—Shatavari 1/2 2x warm water
SP—Manjistha, any bitter 1/2 2'x
BL—Shilajit 1/4 2x, Godshura, cumin, 1/4
KD—Punarnava 1/2 2x.