Peace Love Ayurveda Intake Form

Wellness Coaching Sessions with Jennifer

Name:

Address:

Phone:

Email:

Birthday:

Gender Identity:

Emergency Contact Name & Number:

Referral Source:

Welcome! I'm so excited that you're interested in Wellness Coaching Sessions! My sessions are rooted in the wisdom of Ayurveda. Ayurveda is a system of natural healing, originating in India, that has been practiced for thousands of years. With the support of your Wellness Coach, you can begin your journey to wholeness through achieving balance in body, mind, & spirit.

Please note your Wellness Coach is not a medical doctor or mental healthcare provider and only serves to educate in the system of Ayurvedic wellness. Your coach is not a substitute for medical care and will not diagnose, treat, or prescribe for any disease or pathological condition. For specific symptoms, your coach may recommend that your condition be evaluated by a licensed healthcare provider of Clinical Ayurvedic Specialist (CAS).

If you are under medical care or under the care of another healthcare provider, your work with your Wellness Coach will complement the work being done by your other providers. Please do not discontinue the use of any medication without first speaking to your physician.

The information provided on this Intake Form will be held in the deepest confidence. Please fill it out to the best of your ability.

My signature below acknowledges the above statements as fully read and understood.

Client's signature Date

Ayurvedic Wellness Coach Signature Date

Concerns & Goals

What encouraged you to want to meet with an Ayurvedic Wellness Coach? What are your end-goals?

History of Health Concerns

Are you currently working with a healthcare provider for treatment? If yes, please include details.

How long have you been working with healthcare professionals? Are you noticing any improvement in symptoms?

Are there any past medical conditions that could help me to better understand your health and create a plan for lifestyle change?

How would you describe your health during childhood?

Daily Routine (Dinacharya)

How would you describe your routine on most days?

Morning:

Mid-Morning:

Afternoon:

Mid-Afternoon:

Evening:

Is this routine different from your ideal routine? If yes, please describe your ideal routine.

What time do you get up in the morning? Is this the same every day?

How do you feel when you wake up (well rested, tired, etc.)?

How would you describe the quality of your sleep? Do you wake up frequently, have trouble falling asleep, have nightmares, sleep soundly?

Do you nap during the day?

What time do you go to bed? Is this the same every night?

What does your evening/bed-time routine look like?

Diet & Movement

What is your dietary preference (omnivore, vegetarian, vegan, pescetarian, etc.)?

Do you consume any of the following? If yes, how often do you consume it?

Carbs:

Fruits:

Vegetables:

Alcohol:

Caffeine:

Dairy:

Meat:

Soda or Sugar:

Tobacco:

How much water do you drink per day?

Do you enjoy cooking?

Do you tend to cook for yourself or eat out more?

What is your biggest meal of the day?

Describe what you typically eat during the day:

Describe your eating habits (do you eat at a table or while watching tv? Do you eat quickly or slowly?):

Are you currently prescribed any medications or herbs? If so, please list.

Are there certain tastes you have cravings for (sweet, salty, hot/spicy, sour, etc.)?

Do you eat between meals? If so, what do you snack on?

Are you hungry upon waking?

How long are you awake before eating your first meal?

Do you experience any of the following symptoms after eating?

___ Bloating ___ Belching ___ Acid Reflux

___ Nausea ___ Sleepiness ___ Sluggishness

___ Abdominal Pain ___ Heaviness ___ Fatigue

___ Heartburn ___ Gas ___ Indigestion

___ Other, explain:

What most accurately describes your elimination patterns?

___ 1 time per day ___ 2-3 times per day ___ Once every 2-3 days

___ First thing in morning ___ Later in the day ___ Immediately after dinner

___ Need to use a laxative

Are your stools soft, medium, or hard?

Do they feel complete?

Check all that apply:

___ Mucousy ___ Foul Smelling ___ Floating

___ Dark Brown/Black ___ Yellow/Green ___ Pale ___ Light Brown

___ Straining to go ___ Wipes multiple times ___ Sinks

___ Leave residue on toilet bowl ___ Burns upon elimination

Do you travel frequently? Please explain.

Do you have a commute? How long and how often?

What sort of exercise/movement do you participate in?

How often do you exercise and how long is each session?

Is the intensity of your exercise session light, medium, or heavy?

Is there anything else you'd like to share about your diet and exercise routines?

Relationships & Reproductive Health

What is your current relationships status or most recent relationship?

How fulfilled/satisfied do you feel with this relationship?

Do you currently have a menstrual cycle?

If so, would you consider it regular?

When was the first day of your last cycle? How long did it last?

Is the flow typically light, medium, or heavy?

Do you have cramping or pain? If so, does it vary depending on the day of your cycle?

Do you experience any of the following: changes in mood, bloating, acne/rash, cravings, fatigue, depression, anxiety, breast tenderness, intense dreams, or anything else.

What products do you use during your cycle?

Are you experiencing any symptoms of menopause or peri-menopause (hot flashes, mood swings, irregular cycles, difficulty sleeping, vaginal dryness, loss of libido?)

Do you use birth control and if so, what method? Have you experienced side effects?

Are you or have you ever been pregnant? If so, how many times? Have you ever miscarried?

Have you ever had complications during pregnancy, birth, or after?

The Mind

Have you ever been diagnosed with a mental illness? Has anyone in your family been diagnosed?

Have you ever experienced symptoms of a mental illness or mental health concern?

Do you regularly feel any of the following:

☐ Anxious ☐ Overwhelmed ☐ Self-destructive

☐ Resentment ☐ Anger ☐ Depressed

☐ Intense ☐ Melancholy ☐ Stubborn

☐ Lonely ☐ Fear ☐ Panic ☐ Irritated

☐ High level of stress ☐ Lethargic ☐ Worry

☐ Other

Please explain anything you've checked above.

How well do you handle stress?

How do you currently handle stress?

Have you ever been addicted to any substance? If so, what and how long?

Work and Life

Do you currently work? What kind of work?

Do you enjoy your work?

What are your major activities during the week? (school, work, activities with children, etc.)

Monday:

Tuesday:

Wednesday:

Thursday:

Friday:

Saturday:

Sunday:

Do you have hobbies that you enjoy?

How often do you get to participate in them?

What are you most passionate about?

Do you engage in spiritual practices (prayer, meditation, breathwork, etc.?)

What is your current relationship to Spirit/God/Divine/Nature? What does this relationship look like for you?

Do you have rituals or cultural practices you would like me to know about?

Constitution (Prakruti) Evaluation

This section will be completed with your Wellness Coach during your first session.

	VATA	PITTA	KAPHA
Body frame	Thin, ectomorphic	Muscular, mesomorphic	Stout, stocky, endomorph
Bones	Light, narrow bones and/or prominent joints	Moderate bone structure, medium	Heavy, thick
Body weight	Light or variable	Moderate, muscular	Can be overweight
Complexion/Skin	Dry, rough, cool, thin, gray	Rosy, ruddy, oily, moderate thickness	Thick, pale, moist, cool

Hair	Dry, course, curly, brittle	Fine, light in color, oily, early gray, baldness	Thick, oily, lustrous. wavy
Teeth	Irregular, crooked	Moderate, yellowish teeth	Regular, strong, white, healthy
Eyes	Small	Medium, deep-set, sharp, blue or green	Large, luxurious lashes
Nose	Narrow, small	Medium	Large, wide bridge
Lips	Thin, small, may looked chapped	Medium	Thick, large
Chin	Thin, angular	Tapering, angular	Rouded, double
Neck	Thin, Long	Medium	Thick, short
Fingers & Palm	Thin, long, narrow	Medium, square	Thick, fleshy, short
Face	Oval, thinner	Angular	High, Round
TOTAL			

	VATA	PITTA	KAPHA
Appetite	Variable, scanty, may have extremes	Good, strong	Steady, consistently low
Sweat/Body odor	Little, smell	Profuse, strong	Pleasant or sweet smell, profuse
Sleep	Light, interrupted or restless	Light to Moderate, can awaken & fall asleep easily	Difficult to wake up
Digestion/Elimination	Dry, hard, varies, tendency toward gas and constipation	Soft, sometimes loose or burning, 1-3 times per day	Regular, solid, sometimes sluggish
Temperature	Cold	Warm /Hot	Cool

Menses	Painful cramping, irregular cycle	Heavy flow, regular	Moderate flow, mild cramping
TOTAL			

	VATA	PITTA	KAPHA
Mind	Restless, always active, scared, timid	Adventurous, bold	Conservative, shy
Under stress	Anxious, variable	Focused and intense	Calm, stable, conservative
Speech	Rambling, quick	Can be argumentative Can be clear & concise	Steady, slow to change, Gentle
Memory	Quick to understand, quick to forget	Sharp	Slow to take notice but won't forget
Nature	Independent	Leader	Supporter
Moods	Adaptable, playful	Courageous, passionate	Loving, stable, calm
Negative emotions	Fear	Anger	Attachment
Focus	Trouble being focused	Detail-oriented	Big picture
Decision Making	Trouble making choices	Quick to decide	Slow to make decisions
TOTAL			