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awaken ayurveda & yoga therapy

AYURVEDA QUESTIONNAIRE

PERSONAL DATA:

NAME_____DATE:_____

PHONE_____EMAIL_____

MAILING ADDRESS:_____

AGE:_____DOB:_____GENDER:_____

BUSINESS/OCCUPATION/GENERAL SCHEDULE_____

_____

WHAT ARE YOUR GOALS FOR YOUR WELLNESS CONSULTATION TODAY?_____

_____

_____

ARE YOU ALLERGIC TO, OR INTOLERANT OF, ANY HERBS, SPICES, FOOD, OR ANY SENSITIVITIES I SHOULD BE AWARE OF?__

_____

Do you currently engage in any activities that could compromise your health or would be considered unhealthy?_____

_____

Do you have any current health concerns or problems?_____

_____

_____

Do you have any significant previous health concerns or problems?_____

_____

Any significant family history of health problems?_____

_____

Please list all prescription medications, birth control, hormone replacement, vitamins, herbs, and supplements you take

_____

_____

Previous Ayurvedic evaluations and treatments (if any): _____

List date and place of most recent previous Ayurvedic evaluation, if any: _____

List date and place of most recent in-residence Ayurvedic programs, if any:_____

Please list foods you typically eat for:

Breakfast:

Lunch:

Dinner:

Snacks:

Any special dietary needs?

BODY WEIGHT: Height: _____ft. _____ in. Weight: Now _____, 1 year ago _____

Highest weight: _____ When? _____ Lowest weight: _____ When? _____ __

Any weight gain or loss in the past 6 months? (# of pounds, + or -) _____

DIGESTION:

1. Is your digestion: ☐ Good ☐ Fair ☐ Poor
2. Is your appetite: ☐ Strong ☐ Moderate ☐ Mild ☐ Variable
3. In general, how is your energy during the day? ☐ Strong ☐ Medium ☐ Low ☐ Variable
4. Do you often feel heavy after eating? ☐ Yes ☐ No
5. Do you often feel sleepy after eating? ☐ Yes ☐ No
6. Do you have problems with (please circle):
   Gas flatulence belching bloating heartburn/acid reflux constipation diarrhea

Other:_____

7. Are there any foods that cause discomfort? _____

ELIMINATION:

1. Do your bowel movement tend to be? ☐ Regular ☐ Irregular
2. How often do you have bowel movements? ☐ More than 3 times a day ☐ 2-3 times per day
   ☐ Once daily ☐ Less than once every 3 days
3. When do you usually have bowel movements? ☐ First thing in the morning ☐ Later in the morning ☐ In the afternoon
   ☐ Immediately after meals ☐ At night after dinner
4. Stools are usually: ☐ Soft ☐ Medium ☐ Hard ☐ Variable Consistency
5. Do you use enemas or laxatives? ☐ No ☐ Yes How often?_____
6. Do you have hemorrhoids? ☐ No ☐ Yes If yes, do they bleed? _____

DIET AND EATING BEHAVIOR:

1. Is your diet: ☐ Non-vegetarian ☐ Mostly vegetarian ☐ Vegetarian ☐ Vegan
2. Which is your main meal? ☐ Breakfast ☐ Lunch ☐ Dinner
3. Do you eat between meals? ☐ Yes ☐ No
4. How much time do you take for: Breakfast _____ Lunch _____ Dinner _____
5. Do you sit for 5-10 minutes after finishing a meal (circle one)? ☐ Yes ☐ No
6. Do you feel you now have or have had in the past an eating disorder? ☐ Yes ☐ No

7. How often do you eat the following?
Leftovers? ☐ Often ☐ Sometimes ☐ Rarely ☐ Almost never
Frozen foods? ☐ Often ☐ Sometimes ☐ Rarely ☐ Almost never
Packaged foods/processed foods ☐ Often ☐ Sometimes ☐ Rarely ☐ Almost never
Cold foods and/or drinks? ☐ Often ☐ Sometimes ☐ Rarely ☐ Almost never
Raw vegetables (salad)? ☐ Often ☐ Sometimes ☐ Rarely ☐ Almost never
Red meat? ☐ Often ☐ Sometimes ☐ Rarely ☐ Almost never
Spicy foods? ☐ Often ☐ Sometimes ☐ Rarely ☐ Almost never
8. How many times per week do you eat out in a restaurant? _____
9. How often do you microwave your food or drinks? ☐ Often ☐ Sometimes ☐ Rarely ☐ Almost never
10. About what percentage of your food is organically grown or bought?_____ 11. How many soft drinks or diet soft drinks do you drink each week? _____

SLEEP:

1. Is your sleep disturbed? ☐ Not all ☐ Somewhat ☐ Moderately ☐ Severely ☐ Very Severely
2. Do you take sleep aids? _____
3. What time do you usually go to bed (lights out)? _____
4. What time do you usually wake up? _____
5. Are your bedtime & arising times regular from day to day? ☐ Regular ☐ Mostly regular ☐ Somewhat regular ☐irregular

PSYCHOLOGY:

1. How would you describe your mood?
_____

2. Do you suffer from? (circle relevant)
Anxiety depression anger mood swings insomnia

3. Are you currently in psychological counseling? ☐ Yes ☐ No

DAILY ROUTINE:

1. How regular is your daily routine (for example, do you go to bed, get up, and eat your meals around the same time daily)? ☐ Very regular ☐ Somewhat regular ☐ Not very regular ☐ Very irregular
2. Do you go to bed early (by 10:00-10:30 pm)? ☐ Yes ☐ No 3. Do you get up early (by 6:00-6:30 am)? ☐ Yes ☐ No
4. Do you eat your meals on a regular time? ☐ Yes ☐ No
5. How often do you exercise? ☐ Regularly ☐ Occasionally ☐ Never
6. What type of exercise do you do, if any? _____
7. Is your exercise? ☐ Vigorous ☐ Moderate ☐ Light ☐ None
8. Do you practice meditation? ☐ Yes ☐ No a. How often? ☐ Regularly ☐ Occasionally ☐ Never b. What kind?
_____ _____
Do you practice yoga? ☐ Yes ☐ No a. How often? ☐ Regularly ☐ Occasionally ☐ Never b. What kind?
_____ _____
9. Do you take daytime naps? ☐ Often ☐ Sometimes ☐ Rarely ☐ Almost never
10. Do you travel a lot? ☐ Yes ☐ No
11. How often do you: a. Smoke: _____ b. Drink alcohol: _____
12. Do you feel you take enough time for yourself? ☐ Yes ☐ No
13. How many hours per day do you use a computer? _____
14. How many minutes per day on a cell phone? _____
15. Are you having work or family problems that are impacting your health? ☐ Yes ☐ No
16. Do you perform “cleansings’? ☐ Yes ☐ No Describe: _____

ENVIRONMENT:

1. What direction does your house face? (N/NE/E/SE/S/SW/W/NW) _____
2. What side of the house do you enter? (N/NE/E/SE/S/SW/W/NW) _____
3. What direction does your head of your bed point towards? (N/NE/E/SE/S/SW/W/NW) _____
4. Do you live near a power plant or high tension wires? ☐ Yes ☐ No
5. Are you exposed to chemicals, pesticides or other toxins on a regular basis? ☐ Yes ☐ No
6. Have you recently painted or renovated your home or office? ☐ Yes ☐ No
7. Any other environmental issues I should be aware of?

SECTION FOR WOMEN:

Menstrual History:

Age of onset: _____Date of last period: _____Date of last GYN exam: _____

Any abnormalities? ☐ Yes ☐ No (If yes, describe) _____

Do you take birth control pills? ☐ Yes ☐ No Length of time taking: _____

1. Which of the following describes your menstruation? (Choose as many as apply) ☐ Regular ☐ Absent ☐ Irregular ☐ Too frequent ☐ Infrequent ☐ Menopause (If you are post-menopause, please skip to Question 5)
2. How many days does your cycle last? ☐ Zero to 4 days ☐ 5 to 7 days ☐ More than 7 days ☐ Spotty/irregular
3. Is your menstrual flow? ☐ Heavy ☐ Light ☐ Normal
4. Associated symptoms (before or during Menstruation): ☐ None ☐ Fluid retention ☐ Pain ☐ Acne ☐ Other

_____

5. Do you have any discharge outside of your menstrual period? ☐ Yes ☐ No
6. Do you have any itching of vaginal area? ☐ Yes ☐ No
7. Pregnancies: a. Are you pregnant now? ☐ Yes ☐ No ☐ Don't know b. Number of children: ____c. Number of pregnancies: _____d. Describe any complications with pregnancy: _____
8. Any other diagnoses I should be aware of: (fibroids, hysterectomy, tubal ligation, etc)_____

_____

PHYSICAL CHARACTERISTICS

FACE	oval, oblong or narrow	angular with strong features	round, soft features
EYES	small	deep set, medium	large
NOSE	narrow or crooked	medium width	wider, flatter
COMPLEXION	lack luster or dusty, greyish	rosy, ruddy, easily flushed	pale
LIPS	thin	medium thickness	full
HAIR	coarse, scanty, dry	fine, oily, may be early grey	thick, moist, full
SKIN	thin	medium	thick
BONES	narrow and long	medium & stronger	thick, strong, stocky
NECK	long	medium	short, thick
HANDS	rectangular palm, long fingers	square palm, medium fingers	square fleshy palm,short fingers
FINGERNAILS	thin, fragile	medium & stronger	thick & strongest
WEIGHT/BODY FAT	light or frequent ups & downs Difficulty gaining weight	moderate/relatively steady w/slow gain midlife	consistently heavy & stocky throughout life
MUSCULATURE	minimal, slight	moderate, strong, defined	bulky, stocky
BODY BUILD	irregular, slight, ectomorph	moderate, mesomorph	stocky, bulky

NORMAL CONSTITUTIONAL FUNCTIONS

APPETITE	Picky, variable, forget to eat, little things cause appetite loss	Consistently strong and not easily lost (hangry)	Consistently low, small meals, easily full feeling
DIGESTION	Gas and bloating frequently Gas has little odor	Burning indigestion or smelly gas are common challenges	Feels heavy after meals, food digests slowly
ELIMINATION	Stools are hard. Straining is common. Sometimes skips days	Softer and sometimes loose. Eliminates 1-3 times per day.	Eliminates once per day. Solid, Loglike. Unbalanced – mucousy.
SWEAT	Does not sweat easily.	Sweats easily w/strong odor	sweats easily with exercise pleasant body odor
BODY TEMP	Feels cold easily enjoys heat	often feels warm, enjoys cool	does not often feel too cold or too hot, not bothered by it
SKIN	dry, rough, lips may crack	oily with tendency for rashes, blemishes, acne, sensitivity	If problems develop they are moist and oily. Skin is soft.
MENSES	cycle often irregular & painful Bleeding is light, 2-4 days	Cycle is regular. Flow is heavy for 3-5 days.	The cycle is regular, flow is Moderate and lasts 5-7 days.
SLEEP	Light easily disturbed. May be frequent insomnia.	Falls asleep easily and sleeps Well unless it's too hot.	Falls asleep easily, sleeps Deeply, hard to awaken

PSYCHOLOGICAL CONSTITUTION

Personality balanced	Bubbly or enthusiastic	focused and friendly	kind and sweet
Role in relationships	cheers others on	takes a leadership role	prefers quiet supportive role
Mental tendencies under stress	Hard to deal with stress. May Be scattered or overwhelmed	Becomes more intense, focuses and develops a plan	does not appear very affected by stress, may become quieter
Moods	Mood swings, anxiety common	more critical when angry	experiences melancholy
Decision Making	Often indecisive	usually makes quick decisions stays w/them unless new info	Makes decisions slowly then sticks w/them, to stubborness
Voice and Speech	Fast speech, with a tendency to ramble	likes to make a good point, convincing and clear.	slow with few words
Projects Approach	inspired to start, but can be difficult to finish	Inspired to begin, develops a clear plan to follow. Usually finishes what begins, efficient	Less inspired to start, but once started usually finishes, rarely in a rush
Emotional tendency	nervousness, anxiety, worry fluctuations anxiety/depressior	anger, intensity, resentment, judgment, jealousy	Melancholy, sentimental, uninspired, complacent, lethargy

CURRENT SYMPTOMS (VIKRUTI)

Gas and distention	Burning indigestion, occasional smelly gas	Appetite loss, sluggish digestion
constipation	Loose stools	Mucousy stools
Dry skin	Reddened rashes or acne	Feel heavy in abdomen
Cold Sensitivity	Heat sensitivity	water retention and swelling
Cramping, shooting, electrical,chronic pain	Burning or searing pains	dull, achy pain, stiffness
Weak bones (osteoporosis), joint pain or fragile nails,	Red Eyes	Excess eye secretions
Spotty hair loss	Inflammation anywhere in the body	Muscle heaviness
Tremors, tics, or twitches	Infections anywhere in the body	Benign tumors & cysts
Infertility due to weakness of egg/sperm	Anger, intensity or too critical	Difficulty processing info
Irregular and/or spotty menses	Sharper words	Lethargy
Anxiety, worry, fear, overwhelm	Loss of patience, demanding	Melancholy, quieter than usual
Increased rambling in voice	Sun sensitivity	Excess white film on tongue
Mood Swings	Yellowish film on tongue	Inability to speak or socialize

AMA QUESTIONNAIRE PLEASE MARK TO WHAT DEGREE OF AMA (IMBALANCE) IS BUILDUP IN YOUR BODY APPLY TO YOU (1=0% AND 5=100%)

	0%	25%	50%	75%	100%
1. I tend to feel obstruction/blockages in the body. (Constipation, congestion/heaviness is the head area, blocked nose, general feeling of non-clarity, or other)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
2. When I wake up in the morning, I do not feel clear; it takes me quite some times to feel really awake.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
3. I tend to feel tired or exhausted mentally and physically.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
4. I get common colds or similar ailments several times a year	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
5. I tend to feel heaviness in the body	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
6. I tend to feel that something is not functioning properly in the body. (breathing, digestion, elimination, or other)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
7. I tend to be lazy, e.g., the capacity to work is there, but there is no inclination	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
8. I often suffer from indigestion.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
9. I tend to have to spit repeatedly.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
10. Often I have no taste for food and no real appetite.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
11. My tongue is often coated – especially in a.m.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

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