



# REGISTRATION & CONTACT INFORMATION

Dr. Alexandra Porter, ND | Dr. Cynthia Senter, ND | Greg Fulton, LMP  
Positive Touch Medicine | 4507 Sunnyside Ave N, Suite D | Seattle, WA | 98103  
Phone: 206-547-5510 | Fax: 206-547-5517 | [www.positivetouchmedicine.org](http://www.positivetouchmedicine.org)

**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



## SCHEDULING AND APPOINTMENT POLICIES

**POSITIVE TOUCH MEDICINE** | Dr. Alexandra Porter | Dr. Cynthia Senter  
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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.**

The first missed appointment fee may be waived. The second will result in a charge of \$75.00 to your account. The third missed appointment will result in a charge that covers the cost of the visit (up to \$150.00) and will only be allowed to schedule same-day appointments or may be dismissed from the clinic.

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.

### NEW PATIENTS AND FIRST OFFICE CALLS

Due to the longer amount of time that first office calls require, new patients who cancel or reschedule without adequate notice will no longer be able to schedule an appointment until they pay a \$75.00 missed appointment fee. They will not be able to schedule with any other practitioner at this practice until this fee is paid.

**\*\*\*IF YOU HAVE ANY QUESTIONS, COMMENTS, OR CONCERNS ABOUT THE POLICIES OUTLINED IN THIS DOCUMENT, PLEASE NOTIFY ADMINISTRATION IMMEDIATELY\*\*\***



## ELECTRONIC COMMUNICATIONS POLICY

Dr. Alexandra Porter, ND | Dr. Cynthia Senter, ND | Greg Fulton, LMP  
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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.

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### \*\*\*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

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Signature of patient or parent/legal guardian

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Date signed



# Insurance Questionnaire

4507 Sunnyside Ave N, Ste D Seattle, WA 98103 • Ph 206.547.5510 • Fx 206.547.5517 • .positivetouchmedicine.org

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?  Yes: \_\_\_\_\_  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 questions:**

- 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 (such as cholesterol, CBCs)?  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 INFORMATION**

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.

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SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN

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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 warranties 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



**Positive Touch**  
**MEDICINE**

Cynthia Senter, ND | Alexandra Porter, ND  
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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:

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**DIET, SLEEP, AND EXERCISE**

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

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**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	<input type="checkbox"/>				
Diabetes	<input type="checkbox"/>				
Chemical dependency	<input type="checkbox"/>				
Mental illness	<input type="checkbox"/>				
Asthma, hay fever, hives	<input type="checkbox"/>				
Anemia	<input type="checkbox"/>				
Kidney disease	<input type="checkbox"/>				
Glaucoma	<input type="checkbox"/>				
Tuberculosis	<input type="checkbox"/>				
Genetic disorders	_____	_____	_____	_____	_____
Other (please explain)	_____	_____	_____	_____	_____

**GENERAL INFORMATION**

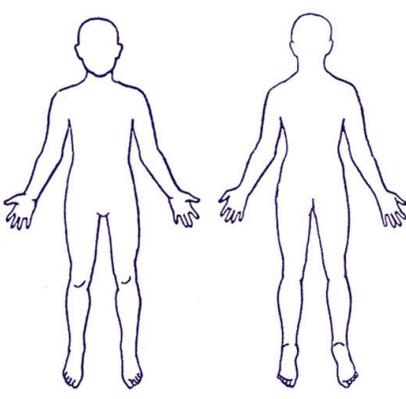
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Highest weight: \_\_\_\_\_ Weight 1 year ago: \_\_\_\_\_

**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.			Yes	No	Prev.	
<b>SKIN</b>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BLOOD</b>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Inflammation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Easy bleeding/bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<b>LUNGS</b>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Abnormal growths	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Change in hair/nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>HEAD</b>	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	....when lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	....at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>EYES</b>	Impaired vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>HEART</b>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>EARS</b>	Impaired hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Ringing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Earache or itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations, fluttering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>NOSE</b>	Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>DIGES- TION</b>	Trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Sinus issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Change in thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>THROAT &amp; MOUTH</b>	Frequent sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Sore tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Mouth/lip sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Freq of bowel movements:	<hr/>			
	Gum disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Change in frequency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Loose stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Dental issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>URINARY</b>	Pain on urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching, gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Increased frequency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver/gall bladder dz.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	....at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Inability to hold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>OTHER</b>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Bladder infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Vertigo, dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

		Yes	No	Prev.			Yes	No	Prev.
<b>CIRCULATION</b>	Deep leg pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>FEMALE REPRODUCTION</b>	Bleeding betw. periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cold hands/feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Irregular cycles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>NEUROLOGICAL</b>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		PMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Abnormal discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Excessive flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Difficulty conceiving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Menopausal symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Memory loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Are you sexually active?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ENDOCRINE</b>	Thyroid issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Pain during intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Heat/cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Bleeding after intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Age when menses began	_____		
	Excessive hunger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Avg days of menstruation	_____		
	Easy weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Avg days of cycle	_____		
<b>EMOTIONAL</b>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Date of last period	_____		
	Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		No. of pregnancies	_____		
	Anxiety/nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		No. of live births	_____		
	Tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No. of miscarriages	_____			
	Joint pain/stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No. of abortions	_____			
<b>BONE &amp; MUSCLE</b>	Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type of birth control	_____			
	Muscle spasm/cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last PAP smear	_____			
	Pain (indicate below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	>any abnormalities?	<input type="checkbox"/>	<input type="checkbox"/>		
 <p>Indicate any problem areas on the diagram above.</p>					Do you perform regular self breast exams?	<input type="checkbox"/>	<input type="checkbox"/>		
					Breast lumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					Breast pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<b>MALE REPRODUCTION</b>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Testicular masses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Prostate issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Discharge or sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**OPTIONAL QUESTION:** What is your sexual orientation? \_\_\_\_\_

# Ayurvedic Constitution Quiz

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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 0 to 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.