(2) FAMILY HISTORY

Indicate what members of your immediate family have had these conditions. (Go back one generation)
(If adopted, answer according to family heritage, if known.)

☐ High Blood Pressure _____ ☐ Heart Disease _____ ☐ Other _____
☐ Cancer _____ ☐ Mental Disorder _____ _____
☐ Stroke _____ ☐ Diabetes _____ _____

(3) ALCOHOL, TOBACCO AND SUBSTANCE USE

PRACTITIONER NOTES:

a. Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how often: ☐ *Daily* ☐ *Several times weekly* ☐ *Several times monthly* ☐ *Seldom* How many glasses? _____ I usually choose: ☐ beer ☐ wine ☐ sweet or hard liquor	
b. Have you ever smoked tobacco? ☐ Yes ☐ No If yes, how much per day?_____ Have you ever smoked marijuana? ☐ Yes ☐ No If yes, how much per day?_____ If you have quit smoking, what year did you quit? _____	
c. Any current or past use of other addictive or habitual substances? ☐ Yes ☐ No ***(Note: This will be kept confidential)*** Please list all substances (either current or long-term past usage):_____ _____ _____	

(4) REGULAR PRACTICES

☐ EXERCISE/HATHA YOGA *(Specify)*	☐ *None/Never*	☐ *Occasional* ☐ *Daily*	☐ *Several times per week* ☐ *Several times per month*
☐ TEAM SPORTS/RECREATION *(Specify)*	☐ *None/Never*	☐ *Occasional* ☐ *Daily*	☐ *Several times per week* ☐ *Several times per month*
☐ TRAVEL *(Include commute if applicable)*	☐ *None/Never*	☐ *Occasional* ☐ *Daily*	☐ *Several times per week* ☐ *Several times per month*
☐ SPIRITUAL PRACTICES *(Specify)*	☐ *None/Never*	☐ *Occasional* ☐ *Daily*	☐ *Several times per week* ☐ *Several times per month*
☐ MEDITATION/PRAYER/PRANAYAMA *(Specify)*	☐ *None/Never*	☐ *Occasional* ☐ *Daily*	☐ *Several times per week* ☐ *Several times per month*
☐ OTHER *(Include creative activities)*	☐ *None/Never*	☐ *Occasional* ☐ *Daily*	☐ *Several times per week* ☐ *Several times per month*

(5) RELATIONSHIP

a. Please indicate how nourished you feel in your relationship: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
(1 being the least nourished, 10 being the most nourished)

b. How often do you engage in sexual activity (include sex with partner and masturbation):
☐ *Daily* ☐ *Several times per week* ☐ *Several times per month* ☐ *Occasionally* ☐ *Not at all*

c. Is your current sexual activity satisfactory? ☐ *Yes* ☐ *No*

Practitioner Notes:_____

(6) Food Choices (Please be as detailed as possible)
List below what types of foods you eat on a regular basis? What percentage of your food is organic?_____

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

(7) **DAILY LIQUID INTAKE** *(Indicate number of 8 ounce cups per day)*

☐ Plain water _____

☐ Caffeinated Coffee/Tea _____ ☐ Herbal Tea or Juice_____ ☐ Cow or Goat Milk _____

☐ Decaffeinated Coffee/Tea _____ ☐ Soda or Diet Soda _____ ☐ Grain/nut/soy milk _____

(8) HABITUAL EATING PATTERNS

Describe any current or past eating patterns or any other food related issues.

(9) **DAILY SCHEDULE** *(include approximate times)*

What are your habitual activities from the time you wake up until you go to sleep? Include mealtimes, sleeping, exercise, work, and any activities that occur on a regular basis.

		TIME	HABITUAL ACTIVITIES	INTERN NOTES
MORNING	Awaken			
	Mealtime			
	Activities			
DAY	Mealtime			
	Activities			
NIGHT	Mealtime			
	Activities			
	Bed-time			

(10) ALLERGIES OR SENSITIVITIES: Do you have allergic reactions to any substances (including food, pollen, medicines?) If yes, please list._____

(11) AYURVEDIC HISTORY

For each category please identify your tendency over time by placing an "X" in the box that is most appropriate for you. If you are unsure or would like to speak to your practitioner about this please check (√) in the column to the right.

CATEGORY				PRACTITIONER USE ONLY √	(FREQUENCY / INTENSITY 1-10)
Appetite	I prefer to eat frequently but my hunger level is variable, and I often forget to eat. ☐ *Practitioner use only* V☐ P☐	I have a strong appetite I prefer to eat 3x/day and rarely skip meals. ☐ *Practitioner use only* V☐ P☐	I prefer to eat 2-3x/day, but I can go without eating with no discomfort. ☐ *Practitioner use only* V☐ P☐	☐	
Appetite	If I miss a meal, I often get light-headed, anxious or cranky. ☐ *Practitioner use only* V☐ P☐	If I miss a meal, I often get critical or angry. ☐ *Practitioner use only* V☐ P☐	If I miss a meal, it doesn't really bother me. ☐ *Practitioner use only* V☐ P☐	☐	
Digestion	After eating, I often experience gas or bloating ☐ *Practitioner use only* V☐ P☐	After eating, I often experience heartburn or acidity. ☐ *Practitioner use only* V☐ P☐	After eating, I often feel heavy or sleepy. ☐ *Practitioner use only* V☐ P☐	☐	
Elimination	I tend to have irregular bowel movements one time per day or less. ☐ *Practitioner use only* V☐ P☐	I tend to have 1 to 2 bowel movements daily, usually with regularity and ease. ☐ *Practitioner use only* V☐ P☐	I tend to have one bowel movement per day with no straining or difficulty. ☐ *Practitioner use only* V☐ P☐	☐	
Elimination	My bowel movements are often dry and hard. At times I may strain or push. ☐ *Practitioner use only* V☐ P☐	My bowel movements are usually well-formed, but sometimes they are loose and may burn. ☐ *Practitioner use only* V☐ P☐	My bowel movements are usually well-formed, slow and easy. ☐ *Practitioner use only* V☐ P☐	☐	
Weight	I usually don't gain weight very easily. ☐ *Practitioner use only* V☐ P☐	When I gain weight, it is easy to lose it. ☐ *Practitioner use only* V☐ P☐	I gain weight easily and lose it slowly. ☐ *Practitioner use only* V☐ P☐	☐	
Body Temperature	My hands and feet often feel cold, and I prefer warmer climates. ☐ *Practitioner use only* V☐ P☐	I am warm most of the time no matter what the climate is. ☐ *Practitioner use only* V☐ P☐	I adapt easily to most conditions, but tend to feel cool. ☐ *Practitioner use only* V☐ P☐	☐	
Sleep	I tend to sleep lightly and awaken very easily. It can be difficult for me to go to sleep. ☐ *Practitioner use only* V☐ P☐	I tend to sleep soundly and awaken with ease. ☐ *Practitioner use only* V☐ P☐	My sleep tends to be deep and long. It can be difficult for me to awaken in the morning. ☐ *Practitioner use only* V☐ P☐	☐	
Skin	My skin tends to be dry. When very dry it tends to feel rough. ☐ *Practitioner use only* V☐ P☐	My skin flushes easily and has a reddish or yellowish shade. ☐ *Practitioner use only* V☐ P☐	My skin is thick, smooth and often feels damp or oily. ☐ *Practitioner use only* V☐ P☐	☐	

PRACTITIONER USE ONLY:

V PRAKRUTI:	**P PRAKRUTI:**	**K PRAKRUTI:**
V VIKRUTI:	**P VIKRUTI:**	**K VIKRUTI:**

*PATIENT NAME:*_____

(11) Ayurvedic History Continued

Mental & Emotional Patterns

Category				√	Practitioner Use Only
Stress	Under stress I often become worried or overwhelmed. ☐ *Practitioner use only* V☐ P☐	Under stress I often become irritable, but usually rise to the challenge. ☐ *Practitioner use only* V☐ P☐	Under stress, I often withdraw to observe or become reclusive. ☐ *Practitioner use only* V☐ P☐	☐	
Decision Making	I am changeable and often have difficulty making decisions. ☐ *Practitioner use only* V☐ P☐	I make decisions easily, but can change my mind with new information. ☐ *Practitioner use only* V☐ P☐	I am careful but easy-going about decisions. ☐ *Practitioner use only* V☐ P☐	☐	
Projects	I like to start projects, but at times have difficulty finishing them. ☐ *Practitioner use only* V☐ P☐	I like to start and finish projects. Completion is important to me. ☐ *Practitioner use only* V☐ P☐	I like working on a project, but prefer to let others start them. ☐ *Practitioner use only* V☐ P☐	☐	
Personality	When I am balanced I feel creative, enthusiastic, and vivacious. ☐ *Practitioner use only* V☐ P☐	When I am balanced I feel perceptive, disciplined, and logical. ☐ *Practitioner use only* V☐ P☐	When I am balanced I feel nurturing, calm, and devotional. ☐ *Practitioner use only* V☐ P☐	☐	

For Women Only

Practitioner Use Only

Is there a possibility you are pregnant? ☐***Yes*** ☐***No*** ☐***Possible*** Are you menopausal? ☐***Yes*** ☐***No*** If yes, date of last period _____ *If menopausal, please answer below according to your past menstrual patterns.*			I experience PMS: ☐*often* ☐*sometimes* ☐*not at all*
My menstrual cycle is irregular. ☐ It comes every ___ to ___ days and lasts ___ days. *Practitioner use only* V☐ P☐	My menstrual cycle is regular. ☐ It comes every ____ days, and lasts ___ days. *Practitioner use only* V☐ P☐		☐*cramps* ☐*bloating* ☐*headache* ☐*weight gain* ☐*irritable* ☐*breast tenderness* *Practitioner use only* V☐ P☐
My menstrual flow is irregular, light, 2-4 days. ☐ *Practitioner use only* V☐ P☐	My menstrual flow is heavy, regular, 3-5 days. ☐ *Practitioner use only* V☐ P☐	My menstrual flow is regular, 5-7 days, sometimes clumping. ☐ *Practitioner use only* V☐ P☐	☐
I often have severe, cramping pain during menses. ☐ *Practitioner use only* V☐ P☐	At times, I have mild pain during menses. ☐ *Practitioner use only* V☐ P☐	I rarely have pain during menses. ☐ *Practitioner use only* V☐ P☐	☐

Practitioner use only:

V Prakruti:	**P Prakruti:**	**K Prakruti:**
V Vikruti:	**P Vikruti:**	**K Vikruti:**

*PATIENT NAME:*_____

(11) CHALLENGING PATTERNS

Please indicate any physical and emotional patterns that *you find challenging* by assigning a ***Frequency*** (a number from 1 to 3) and ***Intensity*** (a number from 1 to 10):

FREQUENCY	INTENSITY
1 = DAILY	1 TO 3 = MILD DISCOMFORT
2 = SEVERAL TIMES WEEKLY	4 TO 6 = MODERATE DISCOMFORT
3 = SEVERAL TIMES MONTHLY	7 TO 10 = SEVERE DISCOMFORT

A. DIGESTION

	Frequency 1-3	Intensity 1-10
Excessive gas		
Excessive belching		
Acid reflux		
Burning indigestion		
Nausea or vomiting		
Sleepy after eating		
Heaviness after eating		
Bloated after eating		

B. ELIMINATION

	Frequency 1-3	Intensity 1-10
Constipation (less than 1 BM/day)		
Alternating constipation & diarrhea		
Food particles in stool		
Diarrhea		
Rectal pain or hemorrhoids		
Blood in stool		
Mucus in stool		
Abdominal pain		

C. EMOTIONS

	Frequency 1-3	Intensity 1-10
Worry		
Anxiety		
Overwhelm		
Self-destructiveness		
Anger		
Resentment		
Critical/Blaming		
Intense		
Lethargic		
Melancholy		
Depression		
Stubbornness		

(12) ADDITIONAL SYMPTOMS OF CONCERN

	Frequency 1-3	Intensity 1-10

(13) PREVIOUSLY DIAGNOSED CURRENT CONDITIONS

	PRACTITIONER NOTES *Please describe symptoms of diagnosed condition*

*PATIENT NAME:*_____

(15) CURRENT MEDICATIONS, HERBS OR SUPPLEMENTS

What medications, herbs, and supplements are you currently taking?
Please include significant remedies that you have stopped *taking, including birth control and hormone replacement therapies.*

Substance	Over-the-counter ***(OTC)*** Prescription? ***(Rx)***	Herb/Drug/ Vitamin?	Prescribed by? ***(Self, MD, other)***	For what purpose?	For how long?	What dosage?	What have the benefits been?

*PATIENT NAME:*_____