Suzanne Nicklas Wellness Ayurveda Intake

**AYURVEDIC CONSULTATION CLIENT INFORMATION**

Name:

Address:

City: State: Zip:

Phone Number: Email:

Date & Time of Birth: Birth Location:

Gender Identity:

Emergency Contact Name: Relation: Phone Number:

Referral Source Name:

### WHAT YOU CAN EXPECT FROM YOUR AYURVEDA CONSULTATION

Welcome, we are so glad you have decided now is the time to thrive.

Ayurveda is a system of natural healing, originating in India, that has been practiced for thousands of years. With the support of your Ayurveda Wellness Coach you can begin your unique journey to wholeness through achieving balance in the body, mind and spirit. Your Coach may suggest changes to your lifestyle, diet, herbs, color therapy, sound therapy, and other natural therapeutics. By changing your lifestyle and living more harmoniously with nature, you will begin to create within your body the optimal environment for healing. To successfully reach goals and make positive changes it is important that you are an active participant on your path to well-being.

Please note that your Ayurveda Coach is not a medical doctor, unless otherwise certified, and serves only 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 disease or pathological conditions. For specific symptoms your coach may recommend that your condition be evaluated by a licensed healthcare professional or Clinical Ayurvedic Specialist (CAS).

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

The Shakti School Ayurveda Intake will be held in the deepest confidence, please fill 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’s signature: Date:

# Presenting Concerns

What encouraged you to want to meet with an Ayurveda Wellness Coach? Please continue on another page if more room is needed.

How long has this been bothering you?

What are the biggest challenges, in regard to your health and wellness, that you are experiencing right now?

How long have you been experiencing them?

# History of Health Concerns

We begin our understanding of self with exploring patterns, family history, and physical functions in the body. This intake serves as a starting point for understanding and shifting into greater harmony.

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

For how long? Are you noticing any improvement in symptoms?

Are there any past medical conditions (i.e., illness, trauma, addictions, excessive stress, or anything else) that could help us better understand your health and create a plan for lifestyle changes?

Please let us know about any clinical disease diagnosis in your family lineage:

How would you describe your health during childhood?

# Daily Routine (Dinacharya)

Now that we have explored your current and prior health concerns, and discussed a little family history we review your current routine in sleep, food, and relationship.

How would you describe your daily routine most days?



Is it different from your ideal routine?

### SLEEP

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

How do you feel when you wake up in the morning (i.e., well rested, tired, etc.)?

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

Do you nap during the day?

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

What does your evening look like a few hours before you go to bed?

Is there anything else you would like to share about your sleep routine?

# Work and Life

Do you currently work? What kind of work?

Do you enjoy the work you do?

How would you describe your typical schedule of major activities during the week (i.e., school, work, activities with children, etc.)?

| DAY | NOTES |
| --- | --- |
| Monday |  |
| Tuesday |  |
| Wednesday |  |
| Thursday |  |
| Friday |  |
| Saturday |  |
| Sunday |  |
|  |  |

Do you have hobbies you enjoy?

How often do you get to participate in them?

What are you most passionate about?

Are there spiritual practices, such as prayer, meditation, or others that are important to you?

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

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

# Diet and Movement

### EATING HABITS

How often do you ingest these foods or substances during a typical week?

|  | NEVER | 1X / WEEK | MULTIPLE TIMES PER WEEK | DAILY | OTHER |
| --- | --- | --- | --- | --- | --- |
| Carbs (bread, pasta) |  |  |  |  |  |
| Vegetables |  |  |  |  |  |
| Meats |  |  |  |  |  |
| Fruits |  |  |  |  |  |
| Dairy Products |  |  |  |  |  |
| Alcohol |  |  |  |  |  |
| Coffee |  |  |  |  |  |
| Tea |  |  |  |  |  |
| Soda (including diet) |  |  |  |  |  |
| Sugar |  |  |  |  |  |
| Tobacco |  |  |  |  |  |
| Recreational Drugs |  |  |  |  |  |

Glasses of water you are drinking per day:

What Temperature? (Hot, Warm, Room Temperature, Cold)

Do you enjoy cooking and how often do you cook for yourself?

Have you ever had any food addictions, eating disorders or related patterns around food?

Describe what you typically eat for: Breakfast

Lunch

Dinner

When is your biggest meal of the day?

Describe your habits while eating. (Where do you eat breakfast, lunch and dinner? Note what your environment looks like and if there are any distractions while eating. What pace do you eat?)

Are you currently being prescribed any herbs or medications? Please list.

### APPETITE/ELIMINATION

Are there certain tastes you crave – sweet, salty, sour, bitter, hot/spicy, oily?

Do you eat between meals? What do you typically snack on?

Are you hungry upon waking?

Are you hungry prior to meals?

Do you experience any of the following symptoms after eating?

 bloating belching acid reflux nauseous sleepy abdominal pain sluggish

 fatigue heartburn heavy indigestion gas other (please specify below)

Please elaborate on any symptoms selected in regard to their frequency, intensity & typical source of disturbance:

What most accurately describes your elimination pattern:

 once every 2-3 days once daily immediately after meals

 2-3 times per day first thing in the morning later in the day

 immediately after dinner need laxative daily other (please specify below)

Are your stools (check all that apply)?

 soft medium hard don’t feel complete

 straining to go painful burning upon elimination foul smelling sinking

 floating mucousy sticky (wiping multiple times or leaves debris after flushing)

 dark brown to black medium brown yellow or green light brown pale

 other (please specify below)

### MOVEMENT

 Do you travel frequently? Please describe:

Do you have a commute? How often? How long is your commute?

What sorts of exercise/movement practices do you participate in?

How often do you exercise? How long do you exercise each time?

Rate the intensity of your exercise: light moderate vigorous

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

# Relationships

We ask these questions to see how you use your energy, which is part of assessment. If any of these questions

make you uncomfortable, please skip them.

Current relationship status, or most recent relationship:

If currently in a relationship, how would you describe the quality of this relationship?



not fulfilling okay good great

Please elaborate:

How would you describe your past intimate relationships?

At what age did you first become sexually active?

What would you state is the past and present state of your sensual health?:

Are you sexually active now (with or without partner)?

Are you satisfied with your sex life? What would you like to be different?

# Reproductive Health for Women

Connecting with nature requires us to tune into our own internal rhythms as well. Answer to the best of your ability.

### MENSTRUATION

Cycle History. For women that have entered perimenopause, menopause, or are postmenopausal, please enter your past tendencies.

Would you consider your cycle regular? If no, please provide additional information.

When was the first day of your last menstrual cycle?

How long does your menstruation last?

Is your menstrual flow typically light, heavy, or moderate? Please describe.

What is the color of your menstrual blood? (brown, dark red, bright red, light red, pink)

Do you have cramping or pain? Does it vary during different parts of your cycle?

Around the time of, or during your menstrual cycle do you experience any of the following: changes in mood, weight gain, acne or rashes, cravings, fatigue, depression, anxiety, yeast, breast tenderness, bloating, intense dreams, etc. (Please circle, add other symptoms, and use extra space provided if explanation is needed)

What products do you use during your cycle?

### PERIMENOPAUSE, MENOPAUSE, AND POSTMENOPAUSAL

Are you experiencing any symptoms of Perimenopause currently? When did the symptoms begin?

Please describe. (i.e., hot flashes, mood swings, difficulty sleeping, vaginal dryness, and loss of libido)

Are you experiencing any symptoms of Menopause currently? When did these symptoms begin?

Please describe.(i.e., hot flashes, mood swings, difficulty sleeping, vaginal dryness, and loss of libido)

If you are Postmenopausal, how long have you been without your period? Are you experiencing any symptoms? Please describe.

### BIRTH CONTROL

What method are you currently using for contraception?

Are you using, or have you ever used, hormonal contraceptives like the pill, patch, ring or other? Do you, or have you ever, used an IUD for contraception?

Have you ever experienced side effects while using any of the above methods of birth control?

Are you, or have you ever used bio-identical hormones?

### PREGNANCY (If you don’t feel comfortable answering any of the questions, please feel free to skip them.)

Are you, or have you ever been pregnant?

Number of times you have been pregnant:

Have you ever miscarried?

Have you ever had an abortion? If so, which method?

Have you ever had challenges with fertility or conception?

Have you ever experienced complications during pregnancy, delivery, or after giving birth? Please describe.

# The Mind

Sit for a moment and notice the rhythm of your breathing. Allow thoughts to arise. What themes do you notice?

### HISTORY

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

Have you ever been treated for, diagnosed with or experienced symptoms of mental illness?

CURRENT EMOTIONAL EXPERIENCE

|  | INTENSITY | FREQUENCY | PRECIPITATING EVENT (IF KNOWN) |
| --- | --- | --- | --- |
| Anxious |  |  |  |
| Overwhelmed |  |  |  |
| Self-destructive |  |  |  |
| Resentment |  |  |  |
| Anger |  |  |  |
| Depressed |  |  |  |
| Intense |  |  |  |
| Melancholy |  |  |  |
| Stubborn |  |  |  |
| Lonely |  |  |  |

| Irritated |  |  |  |
| --- | --- | --- | --- |
| Fear or Panic |  |  |  |
| High level of stress |  |  |  |
| Lethargic |  |  |  |
| Worry |  |  |  |
| Other |  |  |  |
|  |  |  |  |

Please use this space to provide details about what you have checked above:

How well do you believe you handle stress?

What are some of the ways you currently manage stress right now?

Have you ever been addicted to any substance? What and for how long?

# Constitution (Prakruti) Evaluation

To be completed with your Coach during your first session. Please know that discovering your original constitution is not about judging or labeling. It gives us an idea of what balance and harmony can look like in your unique body, mind and spirit. Circle the response that best fits.

**PHYSICAL STRUCTURE**

|  | 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 |  |  |  |

**PHYSICAL FUNCTION**

|  | 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/Elimi- nation | 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 |  |  |  |

**PSYCHOLOGICAL FUNCTION**

|  | 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 |  |  |  |