**Rahgvik Holistics - Client Intake Form**

Welcome to Rahgvik Holistics! We're excited to guide you on your Ayurvedic journey toward optimal health. Please take your time to fill out this form, as it helps us understand your unique constitution, health challenges, and goals. All information provided will be kept confidential and used to create a personalized wellness plan for you.

**Personal Information**

* **Full Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Gender**: ☐ Male ☐ Female ☐ Other (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Email Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Preferred Contact Method**: ☐ Phone ☐ Email ☐ Text
* **Occupation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Emergency Contact (Name & Phone)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Goals and Concerns**

1. **What is the primary reason you’re seeking Ayurvedic support today? (Please check all that apply)**
   * ☐ Digestive issues (e.g., bloating, constipation, indigestion)
   * ☐ Stress management & mental clarity
   * ☐ Weight management or body composition
   * ☐ Skin health (e.g., acne, eczema)
   * ☐ Sleep issues (e.g., insomnia, restless sleep)
   * ☐ Chronic pain or inflammation
   * ☐ General wellness and vitality
   * ☐ Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **What are your top three health goals?**
3. **Have you been diagnosed with any chronic or acute medical conditions (e.g., autoimmune diseases, allergies, gastrointestinal issues)?**
   * ☐ Yes ☐ No

If yes, please provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Are you currently taking any medications or supplements?**
   * ☐ Yes ☐ No

If yes, please list them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Have you had any surgeries or major health procedures in the past?**
   * ☐ Yes ☐ No

If yes, please provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lifestyle and Habits**

1. **Physical Activity**:
   * How often do you engage in physical activity each week?

☐ Never ☐ 1-2 times ☐ 3-4 times ☐ 5+ times

* + Please describe the types of exercise you enjoy or engage in regularly (e.g., walking, yoga, weightlifting, etc.):
  + Do you have any physical limitations or conditions that impact your ability to exercise? ☐ Yes ☐ No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Sleep Patterns**:
   * On average, how many hours of sleep do you get each night? \_\_\_\_\_\_\_\_
   * Do you have trouble falling asleep or staying asleep? ☐ Yes ☐ No
   * If yes, please describe the nature of sleep disturbance (e.g., insomnia, waking up frequently, trouble falling asleep):
   * Do you feel rested upon waking? ☐ Yes ☐ No
2. **Stress Management**:
   * How would you rate your general stress level on a scale of 1-10 (1 being minimal stress and 10 being extreme)? \_\_\_\_\_\_\_\_
   * What are the primary sources of stress in your life? (e.g., work, family, health concerns, financial pressure)
   * Do you have any coping mechanisms or relaxation techniques that help you manage stress? ☐ Yes ☐ No
     + If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dietary and Digestive Health**

1. **Describe your typical daily meals and snacks (please include food and beverage choices):**
   * **Breakfast**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * **Lunch**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * **Dinner**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * **Snacks**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * **Drinks** (Please specify amount of water, tea, coffee, alcohol, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Dietary Restrictions or Preferences** (check all that apply):

☐ Vegetarian ☐ Vegan ☐ Gluten-Free ☐ Dairy-Free ☐ Pescatarian ☐ Low-Carb ☐ Keto ☐ Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Do you have any food allergies or intolerances?** ☐ Yes ☐ No

If yes, please list them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **How often do you experience digestive discomfort? (Check all that apply)**

☐ Bloating ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Indigestion ☐ Nausea

Please rate the severity of your digestive discomfort on a scale of 1-10 (1 being mild, 10 being severe): \_\_\_\_\_\_\_\_

Is there a specific time of day when these symptoms are worse? ☐ Yes ☐ No

* + - If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Do you often crave certain foods or snacks?** ☐ Yes ☐ No

If yes, what do you crave most often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* + Do you have any food sensitivities or intolerances? ☐ Yes ☐ No
    - If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ayurvedic Dosha Assessment**

Based on your physical, mental, and emotional characteristics, Ayurveda categorizes individuals into three primary doshas: **Vata**, **Pitta**, and **Kapha**. Please consider your predominant traits and answer the following questions.

1. **Physical Characteristics**:
   * **Body Type**: ☐ Thin ☐ Medium ☐ Full-figured ☐ Muscular
   * **Skin Type**: ☐ Dry ☐ Oily ☐ Sensitive ☐ Normal
   * **Hair**: ☐ Dry ☐ Oily ☐ Fine ☐ Thick
   * **Hands/Feet**: ☐ Cold ☐ Warm ☐ Average temperature
2. **Mental and Emotional State**:
   * **How would you describe your mood?** ☐ Calm ☐ Anxious ☐ Focused ☐ Easily irritated ☐ Depressed
   * **Are you quick to anger or frustration?** ☐ Yes ☐ No
   * **Do you often feel mentally scattered or overwhelmed?** ☐ Yes ☐ No
   * **Do you tend to be more social or prefer solitude?** ☐ Social ☐ Solitary
   * **How do you react to stressful situations?** ☐ Calm ☐ Anxious ☐ Overwhelmed ☐ React quickly
3. **Energy Levels**:
   * **How would you describe your general energy levels?** ☐ High ☐ Moderate ☐ Low
   * **Do you feel more energized in the morning, afternoon, or evening?** \_\_\_\_\_\_\_\_\_\_\_
   * **Do you feel sluggish or fatigued after meals?** ☐ Yes ☐ No

**Current Ayurvedic Practices or Treatments**

1. **Are you currently undergoing Ayurvedic treatments or therapies (e.g., Panchakarma, herbal remedies)?** ☐ Yes ☐ No
   * If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Have you used Ayurvedic herbs, oils, or treatments in the past?**
   * ☐ Yes ☐ No
   * If yes, please specify which ones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Information**

1. **Do you have any allergies (e.g., to food, herbs, environmental factors)?** ☐ Yes ☐ No

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Any other health concerns or relevant information you would like to share?**

**Consent and Acknowledgment**

I understand that the information provided will be used to tailor an individualized Ayurvedic plan and support my overall health goals. I consent to share my health details and agree to the treatment suggestions provided by Rahgvik Holistics.

This detailed intake form provides a deeper look into the client's physical, mental, and emotional well-being, giving Rahgvik Holistics the tools to create a more customized and effective holistic treatment plan. Please be advised that we are not trained in Western medical diagnosis or treatment, and we are unable to suggest altering your medical care or treatment regimen. Sirisha Karamchedu, your Ayurvedic practitioner, is a graduate of the California College of Ayurveda, Grass Valley, CA.

Ayurveda is recognized by the National Institute of Health Office of Complementary and Alternative Medicine as a form of complementary and alternative medicine in the United States. In California, Ayurveda is a non-licensed profession and was formally legalized through Senate Bill 577 in January 2003. Ayurvedic consultations are considered complementary to licensed health care practices.

While we may take your blood pressure, vital signs, and perform certain examination techniques like a routine medical check-up, these assessments are based on an Ayurvedic perspective and are not intended as substitutes for a medical evaluation. If any findings suggest a possible medical imbalance, we will refer you to a Medical Doctor for further evaluation. The following services are **not** offered:

* + Diagnosis or treatment of pathological conditions.
  + Prescription drugs or medicines.
  + Advice or counseling regarding the diagnosis or treatment of pathological conditions.

By signing below, you acknowledge that you have read and understood the information above and consent to begin a program of Ayurvedic and wellness health care with Rahgvik Holistics.

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_