Health Information and History

CONTACT INFORMATION:

Name: _____ Date: _____

Home Address: _____

City: _____ State/Region: _____ Postal Code/Zip:_____

Mobile Phone: _____ Home Phone: _____ Email: _____

PERSONAL INFORMATION:

DOB: (MM/DD/YYYY) _____ Time of Birth (include AM/PM): _____

Place of Birth: City: _____ State/Region: _____ Country:_____

Age: _____ Gender: _____ Occupation:_____

Marital Status: _____ Children & Ages: _____

Referred by: _____ Family Physician: _____

Primary Care Provider Name & Title: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip:_____

A) Are you currently under a physician's care for a specific medical problem? If yes, for what and for how long?

_____

_____

_____

CONCERNS: Please tell us your present concerns and/or conditions. How long have they troubled you?

_____

_____

_____

B) What would you like to achieve or change in terms of your health and wellness?

_____

_____

_____

History of Smoking: (what, how often, how much, how many years) _____

Drinking Alcohol: (what, how often, how much, how many years) _____

Recreational/Non-prescription Drugs: (what, how often, how much, how many years) _____

What surgeries have you had? (Include dates) _____

Last physical examination: Date: _____ Blood Pressure: _____ Cholesterol: _____

Height: _____ Weight: _____ Weight Changes? _____

What known allergies do you have? _____

What prescription drugs or medications are you currently taking or have taken within the last 6 months?

Prescription:	Reason	Duration taken	Current dosage	Quantity per	Frequency per day	Before/after/during or between meals

Herbal/ vitamin supplements	Reason	Duration taken	Current dosage	Quantity per	Frequency per day	Before/after/during or between meals

Attach additional sheet(s) if necessary

OBJECTIVES:

Please note that **Ayurvedic Consultations do not include medical diagnosis and treatments**. If you are concerned about a medical condition or a latent or potential medical condition you should see a medical doctor.

Please check the items that reflect your main objectives:

☐ 1. I would like an alternative approach to allopathic medicine for managing illness and disease.

☐ 2. I would like to improve my general health and wellness and reduce my vulnerability to illness and disease.

☐ 3. I would like to improve my lifestyle and dietary practices to improve my health.

☐ 4. I would like to change my habits and behavioral patterns to improve my relationships with others.

☐ 5. I would like to manage stress, tension, and worry to attain a more stable emotional nature.

How would your life be different if you were to achieve these objectives to your satisfaction?

_____

_____

_____

C) PERSONAL HISTORY: Do you or your family members have a history of the following? (Please check boxes all that apply)

	Myself	*Maternal*	*Paternal*		Myself	*Maternal*	*Paternal*
Allergies to Food	☐	☐	☐	Stroke	☐	☐	☐
Allergies to Drugs	☐	☐	☐	Cerebrovascular Accident	☐	☐	☐
Dental Treatment Complications	☐	☐	☐	Cancer	☐	☐	☐
Bleeding Gums	☐	☐	☐	Chemotherapy	☐	☐	☐
Contact Lenses	☐	☐	☐	Radiation Treatment	☐	☐	☐
Glaucoma	☐	☐	☐	Hepatitis A	☐	☐	☐
Eye Surgery	☐	☐	☐	Hepatitis B	☐	☐	☐
Pain in the Ear	☐	☐	☐	Hepatitis Non-A / Non-B	☐	☐	☐
Ringing in the Ear	☐	☐	☐	Mononucleosis	☐	☐	☐
Shortness of Breath	☐	☐	☐	Jaundice	☐	☐	☐
Asthma	☐	☐	☐	Anemia	☐	☐	☐
Pneumonia	☐	☐	☐	Gallstone	☐	☐	☐
TB	☐	☐	☐	Kidney Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐	Kidney Stones	☐	☐	☐
Low Blood Pressure	☐	☐	☐	Bladder Disease	☐	☐	☐
Dizziness	☐	☐	☐	Thyroid Condition	☐	☐	☐
Fainting	☐	☐	☐	Thyroid Medication	☐	☐	☐
Seizures	☐	☐	☐	Ulcers	☐	☐	☐
Convulsions	☐	☐	☐	Intestinal Bleeding	☐	☐	☐
Epilepsy	☐	☐	☐	Chronic Constipation	☐	☐	☐
Diabetes	☐	☐	☐	Recurring Diarrhea	☐	☐	☐
Feet or Ankles Swelling	☐	☐	☐	Arthritis	☐	☐	☐
Chest Pain	☐	☐	☐	Implant	☐	☐	☐
Angina	☐	☐	☐	Prosthesis	☐	☐	☐
Heart Murmur	☐	☐	☐	Prolonged Bleeding If Cut	☐	☐	☐
Heart Attack	☐	☐	☐	Psychiatric Treatment	☐	☐	☐
Heart Disease	☐	☐	☐	Venereal Diseases (STDs)	☐	☐	☐
Heart Surgery	☐	☐	☐	HIV Exposure	☐	☐	☐
Rheumatic Fever	☐	☐	☐	Sleep Disorders	☐	☐	☐

Any other family illnesses not listed ? _____

History of Any Other Disease or Problems? Please list any other personal illnesses, surgeries, diseases, injuries, trauma, emotional stresses, mental stresses, life-style conditions, addictions, alcohol, drug abuse, changes of weight, known allergies, or anything else to help us clearly understand your health condition: _____

_____

_____

EXERCISE: Do you currently engage in any exercise or physical activity? If so, what type(s)?

_____

_____

_____

Have you ever done Yoga postures before? If so, what type(s), how often?

_____

_____

_____

*FEMALES ONLY: Age of onset of menses:_____ Are you currently pregnant? _____ Number of Weeks _____

Number of previous pregnancies:_____ Difficult past pregnancies? _____

Complications: _____

Do you use Birth Control? ☐ Yes ☐ No If so, what type(s)? _____ How long? _____

Date of Last Menstrual Period: _____ Length of cycle:_____ Days between cycles: _____

Cycles: ☐ Regular ☐ Irregular Color of Blood:_____ Flow: ☐ Heavy ☐ Medium ☐ Light

Clots: ☐ Yes ☐ No When? _____ Pain and/or difficulty during cycle? _____

PMS symptoms: _____

Any other symptoms during cycle: _____

Yeast infections? _____ Urinary tract infection (UTI) (frequency, duration): _____

Menopausal stage / symptoms: _____

Other information: _____

*MALES ONLY: Prostate Condition? _____

Other information: _____

Check All That Apply To You Currently And Within The Last Six (6) Months:

Category:			
Digestion	☐ Irregular with ☐ Bloating ☐ Gas/Flatulence ☐ Abdominal Discomfort ☐ Gurgling Intestines ☐ Breathlessness	☐ Quick digestion with ☐ Acid Indigestion ☐ Heartburn ☐ Burning pain ☐ Still hungry after eating ☐ Nausea ☐ Vomiting	☐ Slow digestion with ☐ Feeling of heaviness ☐ Lethargy ☐ Sleepy after eating ☐ Low energy after meals ☐ Excess mucous secretions
Appetite	☐ Irregular ☐ Sometimes eats at midnight	☐ Excess hunger ☐ Sharp hunger ☐ Desire to eat large amounts of food ☐ Strong unbearable appetite ☐ Feels hypoglycemic	☐ Emotional eating (No urge for food but still eats) ☐ Dull / No appetite
Cravings	☐ Fried food ☐ Hot spicy food ☐ Meat or other protein	☐ Sweets ☐ Cooling foods & drinks	☐ Hot, sharp, dry & spicy food ☐ Wine or alcohol
Elimination	☐ Tendency toward constipation ☐ Dry ☐ Irregular ☐ Defecates without satisfaction ☐ Passes gas during elimination	☐ Loose stools ☐ Diarrhea	☐ Mucous in stool
Pain	☐ Shifting ☐ Tearing ☐ Moving ☐ Vague ☐ Throbbing ☐ Colicky ☐ Cutting ☐ Excruciating with breathlessness, fear and tachycardia	☐ Burning ☐ Sharp ☐ Hot ☐ Migraine headaches ☐ Sucking pain with fever, nausea and irritability ☐ Intense pain	☐ Dull ☐ Stable ☐ Deep dull aching pain ☐ Can sleep through the pain
Skin	☐ Dry ☐ Cracked ☐ Rough ☐ Thin ☐ Discolored ☐ Patchy	☐ Hives ☐ Rash ☐ Urticaria ☐ Acne ☐ Tender ☐ Warm/hot to touch ☐ Redness ☐ Boils ☐ Ruddy	☐ Excess oily ☐ Thick ☐ Pallor ☐ Cold/clammy ☐ Lustrous ☐ Itchy
Sweating	☐ Scanty or no sweat	☐ Excess ☐ Profuse with body odor	☐ Cold/clammy

Category:			
Sleep	☐ Insomnia ☐ Need night light ☐ Restless ☐ Difficulty falling asleep	☐ Interrupted sleep ☐ Must have complete darkness ☐ Needs to read/TV to sleep	☐ Excess sleep ☐ Daytime napping ☐ Heavy sleeper ☐ Slow to awaken ☐ Hypersomnia
Seasonal Allergies	☐ Breathlessness ☐ Wheezing ☐ Constricted Breathing	☐ Rash ☐ Itching eyes ☐ Hives ☐ Irritation ☐ Inflammation	☐ Runny nose ☐ Watery eyes ☐ Congestion
Food Sensitivity	☐ Night shades ☐ Leftovers ☐ Dry fruits ☐ Raw food	☐ Hot spicy foods ☐ Sour foods ☐ Fermented foods	☐ Dairy products
Muscle Reactivity	☐ Twitching ☐ Cramping ☐ Weakness ☐ Numbness ☐ Tingling ☐ Spasms	☐ Bruising ☐ Tenderness to touch ☐ Sore ☐ Excess heat	☐ Tumors ☐ Cysts ☐ Growths ☐ Generalized weakness
Bone and Joints	☐ Painful ☐ Popping ☐ Cracking ☐ Stiffness ☐ Loose ☐ Osteopenia ☐ Osteoporosis ☐ Medical fractures ☐ Scoliosis	☐ Inflamed ☐ Hot / feverish ☐ Tender ☐ Inflammatory arthritis ☐ Osteomyelitis ☐ Bursitis	☐ Swollen joints ☐ Bone tumors ☐ Bone spurs ☐ Osteosarcoma ☐ Non-inflammation with profuse infusion ☐ Sclerosis
Circulation	☐ Cold extremities (hands, feet)	☐ Burning hands / feet ☐ Bruises easily ☐ Tendency toward bleeding	☐ Cold clammy hands ☐ Varicose veins ☐ Thrombotic element
Body weight	☐ Variable ☐ Can't gain weight ☐ Thin or slender	☐ Stable ☐ Tendency toward hyper metabolism	☐ Tendency to easily gain weight ☐ Over-weight ☐ Obese ☐ Voluptuous ☐ Stout

Category:			
General Symptomatology	☐ Dry cough ☐ Ringing ears ☐ Light-headed ☐ Dryness: external/internal ☐ Hemorrhoid: External/ non- bleeding ☐ Low back ache ☐ Irregular metabolism ☐ Dry mouth ☐ Receding gums ☐ Blackish brownish discoloration ☐ Fatigue ☐ Lack of power, tone & strength ☐ Paralysis ☐ Slipped disc ☐ Hernia ☐ Difficulty sweating ☐ Cold extremities (hands, feet)	☐ Spontaneous bleeding ☐ Hyper-sensitive to smells ☐ Hair loss ☐ Excess thirst ☐ Hemorrhoid: Internal/bleeding ☐ Hot flashes ☐ Tendency toward inflammatory conditions ☐ Acidic saliva ☐ Hyper acidity ☐ Yellowish discoloration ☐ Fainting ☐ High metabolism	☐ Cold ☐ Cough ☐ Congestion ☐ Excess urination ☐ Frequent urination ☐ Fibrocystic ☐ Over salivation ☐ Edema ☐ Slow metabolism ☐ Albuminuria ☐ Lipoma(s) ☐ Cataracts
Mental-Emotional	☐ Transient Depression ☐ Inability to concentrate ☐ Forgetful ☐ Worry ☐ Fear ☐ Anxiety ☐ Insecurity ☐ Loneliness ☐ Nervousness ☐ Grief ☐ Restlessness ☐ Repetitive thinking ☐ Spacey	☐ Extreme depression with suicidal tendencies ☐ Anger ☐ Rage ☐ Resentful ☐ Judgmental ☐ Critical ☐ Envious ☐ Sharp tongued ☐ Vengeful ☐ Intolerant ☐ Irritable ☐ Aggressive ☐ Success-Failure mind set ☐ Seeks power, prestige and position	☐ Prolonged depression ☐ Sloppy ☐ Slow ☐ Confused ☐ Greed ☐ Attachment ☐ Mental lethargy ☐ Resistant to change ☐ Laziness ☐ Unforgiving ☐ Stubborn ☐ Boredom
Nature of response within relationships	☐ Talkative ☐ Uncertain ☐ Anxious ☐ Lonely ☐ Insecure ☐ Excitable ☐ Shy ☐ Spacey	☐ Seeks power, prestige and position ☐ Perfectionist ☐ Competitive ☐ Seeker of knowledge	☐ Based on acquiring comfort and pleasure

Other (Not Listed Above): _____

_____