Health History

Please complete... If you request a copy it will be given for your records

Name:_____Today's Date:_____

Date of Birth:_____Birth Time:_____Place of Birth:_____Age:_____

How would you rate your current health? _Excellent _Good _Fair _Poor

Address: _____

Home phone:_____ Work phone:_____Cell phone:_____

Email address: _____

Present Health Concerns:

What concerns would you like to address with your practitioner? How long have you experienced these conditions?

1. _____
2. _____
3. _____
4. _____

In order to change these conditions, how willing are you to make dietary and lifestyle modifications?
Very willing/ somewhat willing/ not very willing

Please list any other major health concerns, past or present:

_____ _____
_____ _____
_____ _____

Pain/Discomfort Scale: Severity 1 2 3 4 5 6 7 8 9 10 where in body?_____
Duration: how often_____every day?_____ how many weeks/years?_____
What makes it worse/better? _____

Types of health providers you visit (herbalists, acupuncturists, nutritionists, MD's, MT's, etc)**Who?**:

_____ _____
_____ _____
When and where did you last receive medical or health care? Date:_____

Height _____ **Weight** _____ **Blood type** _____

Highest weight ever: _____Year _____ Lowest weight as an adult:_____ year _____
Weight Are you satisfied with your weight? No Yes What do you feel is your optimal weight?

When during the day is your energy the best?_____ worst? _____

Energy Scale: No energy 1 2 3 4 5 6 7 8 9 10
What makes it worse/better? _____
How is your appetite? Never hungry Medium Wavers Very hungry or Very full Always hungry
WHEN did you eat yesterday? Breakfast Lunch Dinner Snacks

WHAT did you eat yesterday? _____ _____ _____

_____ _____ _____ _____

Foods that you prefer to eat:

What cravings do you have and how often? _____

Allergies or Reactions to Foods: _____

Lifestyle Choices/ Social History

Caffeine Consumption: None Sodas: oz/day Chocolate oz/day Coffee/Expresso/Tea cups/day

Alcohol Consumption: None oz/day oz/week oz/month Types

Nutrition: How do you rate the way you eat? Good Fair Poor

Do you eat food to nourish or to comfort yourself? Y N

Work/Career

Occupation: _____ Employer:_____

Career Goals for the next 3 years:_____Education: Highest Level:_____

Home

Who takes care of your home? _____ Marital status: Single Partnered Married Divorced

Name of spouse / Partner _____ Number of Children/ Ages: _____

Who lives at home with you? _____ Do you like your home? No Yes

For Women: # pregnancies # deliveries____ # abortions _____ # miscarriages ___

1st day of most recent period: _____ How many days did it go? _____ *N/A (Ended when:)*

Age at 1st period: ____ Frequency of periods: _____Duration:_____Quantity:_____

Symptoms:_____

Do you have any concerns about your periods? No Yes _____

Do you have any concerns about menopause? No Yes _____

Exercise: Do you exercise daily? N Y Type: Yoga running gym sports housework gardening walking other How often How long

If you do not exercise, why?

Mind and Spirit:

What are you afraid of these days? _____What/who supports you when you fall? _____

Sleep:

Bedtime:_____

Rising Time: _____

Sleep Quality: _____

Feeling Upon Arising:_____

Meditation Frequency: _____

Meditation Type: _____

Digestion: How you process food

How often are your **bowel movements**? Every day: once / several times a day / Once every _____

Frequency: Regular Irregular **What time/s:**

Color: white_____ yellow_____ mid-brown_____ dark-brown_____ black _____

Shape: Long like a banana_____ in pieces_____ has stringy pieces_____ pellets _____ sticky, hard to wipe clean_____

Density: Floats____ Floats, then sinks_____ Sinks_____

Digestion Evaluation:

In the past 7 days, have you felt any of the following symptoms (mark +++, ++, +, 0):

Symptom	Sat	Sun	Mon	Tues	Wed	Thurs	Fri
Passing gas							
Bloating							
Watery BM							
Bellyache							
# of BM's							
Fatigue							
Fog-headed							

Personal Medical History:

Please Indicate your own experience with any of the following medical problems (*include dates*):

___Heart disease ___ Heart attack ___ Diabetes specify type

___Stroke ___ High cholesterol ___ Chronic headache

___Alcoholism ___ Blood transfusion ___ Cancer (malignancy)

___Addiction specify type ___ High blood pressure _____

___ Bleeding Clotting problem ___ Thyroid problems Other problems (specify)
_____

___ Gut/Belly problems ____ Depression/ suicide attempt
_____

Surgical Hospital History:

Please list all prior operations and hospitalizations (with dates):

_____ _____

_____ _____

Medications/Herbs: Prescription medicines, vitamins, home remedies, birth control, herbs:

Issued	Medication	Dose (mg/pill)	When/if each day	When started

Hypersensitivity, Allergies or Reactions to Medicines: _____

Do you currently take or use?

Laxatives Y N Pain Relievers Y N Antacids Y N Other
Cortisone Y N Appetite suppressant Y N Antibiotics Y N
Tranquilizers Y N Thyroid medication Y N Sleeping Pills Y N

When were your most recent Health Maintenance screening tests:

Mammogram:	Results?	Stool test for blood	Results?
Ever abnormal:	Details:	Sigmoidoscopy	Result?
Pap smear:	Results?	Prostate cancer screen	Results?
-Ever Abnormal	Details:	Cholesterol screening	Results?

Review of Symptoms: (please circle any current problems you have on the list below)

Constitutional	***Respiratory***	***Gastrointestinal***	***Neurological***
Fatigue	Sinusitis	Bloating/Gas/Pain	Headaches
Fever/chills/sweats	Cough/wheeze	Acid reflux / heartburn	Numbness
Unexplained weight loss/ gain	Difficulty breathing	Abdominal pain Constipation	Dizziness/ light-headedness
Change in energy/ weakness		Blood in bowel Indigestion	Memory loss Loss of coordination
Excess thirst urination		Nausea/ vomiting/ diarrhea	
Desire for warmth		Heaviness	
Night sweats		Loss of appetite	
Crave sweet/spicy/salty	***Psychiatric / Mind***		
Eyes	Anxiety / stress Fear	***Genitourinary***	***Blood / Lymphatic***
Change in vision	Depression	Nighttime urination	Unexplained lumps
Pain around eyes	Problem with sleep Irritability	Leaking urine incontinence	Easy bruising/bleeding
Ears/nose/throat/mouth	Anger/ Rage	Unusual vaginal bleeding	
Difficulty hearing/ ringing in ears		Discharge: penis or vagina	***Musculo-skeletal & Skin***
Problems with teeth/gums	***Cardiovascular***	Problems with sexual function	Back pain
Cold sensitivity of gums	Palpitations	Breast lump/nipple discharge	Muscle/ joint pain
Hay fever/ allergies	Chest pain/ discomfort		Rash/ mole change

Family History:

What is your heritage? With which cultures or countries do you identify yourself?_____

Any other relevant family history?_____

Please indicate whether any family members have had any of the following conditions and detail:

Medical Condition	Mother	Father	Sibling	Sibling	Child	Child
Alcoholism						
Anemia						
Arthritis						
Asthma/ Hay fever						
Autoimmune disorder						
Bleeding problem						
Breast cancer						
Colon cancer						
Skin cancer						
Ovary/Prostate cancer						

Birth defects						
Depression						
Diabetes Type 1						
Diabetes Type 2						
Eczema						
Epilepsy						
Food allergies						
Hearing problems/ glaucoma						
High Cholesterol						
High Blood pressure/ stroke						
Kidney disease						
Osteoporosis						
Migraine						
Substance abuse						
Thyroid disorders						
Chronic tobacco user						
Other						

Practitioner Use Only

1. Build (visual assessment of Prakriti (Constitution / Body Type)):
2. Movements (including gait):
3. Speech:
4. Face - Shape: Face – Color: Face – Markings:
5. Tongue Body – Shape: Tongue Body – Color:
   Tongue Coating – Character: Tongue Coating – Color:

General Impression:	Pleasant Unpleasant	Comment:	
Ojas Level	0+ 1+ 2+ 3+		
Ama Level	0+ 1+ 2+ 3+		
	VATA	**PITTA**	**KAPHA**
Surface Strength			
Surface Qualities			
Subdoshas	Pr Ud Sam Ap Vy	Pa Ran Sad Al Br	Kl Av Bod Tar Sh
Dhatus			
Deep Strength			
Chakra			
Jyotish			

Consent for Participation

Ayurvedic Counseling & Treatment

Informed Consent / legal waiver:

In this time of increasing patient choices, Lisa Rae Jacoby, asks you to review the following statements and to provide a signature to confirm your agreement:

1. I am voluntarily attending this Ayurvedic health consultation with Lisa Jacoby, a Clinical Ayurvedic Specialist, from my personal interest in my own health and desire to improve my self-care. I understand that I am taking personal responsibility for my health and what I do with my body.
2. I understand that Lisa Rae Jacoby is teaching and leading this personalized program for me in the capacity of a trained clinical Ayurvedic specialist.
3. I understand that Lisa Rae Jacoby is not serving as my primary care physician (PCP), and I understand that I will consult my primary care physician for all emergencies and urgent care, not holding Lisa Rae Jacoby liable for medical emergencies. I acknowledge that I am not deferring necessary medical care.
4. I have chosen to work with Lisa Rae Jacoby voluntarily. I understand that the information I receive is a combination of preventative medicine recommendations, holistic medicine, health counseling, and lifestyle coaching. This combination of approaches is tailored for my overall well-being and is certainly not meant to take the place of seeing appropriate licensed specialists and health professionals.
5. I take full responsibility for my health and for all decisions I make during and following this program, utilizing the knowledge I am given for my personal health.
6. I hereby release and discharge Lisa Rae Jacoby from any and all claims that I or my family or anyone may have now, or in the future. I have read and understood that all of the above, am fluent/ conversational in English, and agree to proceed under these conditions.
7. I understand that the above is meant to have legal significance.

……	…….
Name- please print	Ayurvedic Specialist
…….	……
Signature	Signature
…….	……
Date	Date