AYURVEDIC INTAKE FORM

Client's Name:

Client's Address:

Telephone Number:

Email Address:

Birthdate: Age:

Marital Status:

# of Children: Age:

Occupation:

Chief Health Concerns: Your main health concerns at this time in order of importance.

1.

2.

3.

4.

5.

6.

Past Medical History: Include major conditions, dates of treatment and procedures performed.

1. Serious illnesses:
2. Hospitalizations:
3. Operations:
4. List other pertinent past conditions:
5. Have you been under the care of a licensed health care professional in the past year? Y or N. If so for what reason?
6. Is there any possibility that you are pregnant? Y or N

Family History: Please circle disease and indicate family member.

1. Cancer
2. High Blood Pressure
3. Stroke
4. Diabetes
5. Heart Disease
6. Mental Disorder
7. Other (explain)

Medications or Supplements: What medications, herbs, or supplements are you currently taking? Please include significant remedies that you have recently stopped taking.

Name of substance:
Circle one Prescription over-the-counter herbal vitamin other

Who recommended/prescribed it?

Purpose of substance:

How long have you been taking it?

In what form do you take it (include dosage):

How often do you take it?

What effects have you noticed?

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Circle one Prescription over-the-counter herbal vitamin other

Who recommended/prescribed it?

Purpose of substance:

How long have you been taking it?

In what form do you take it (include dosage):

How often do you take it?

What effects have you noticed?

Review of Symptoms: Circle and explain all symptoms that are of concern to you at this time that you would like to discuss.

Head

Headaches
Dizziness
Fainting spells
Loss of balance
Difficulty remembering
Difficulty thinking clearly
Thinning or loss of hair

Ears

Hearing loss
Ringing
Earaches-Pain
Discharges
Bleeding

Eyes

Pain-soreness in eyes
Redness
Burning
Mucous
Dryness
Itching
Tic/twitch
Blurred/loss of vision

Nose

Loss of smell
Bleeding
Pain
Discharge
Post-nasal drip
Sinus Congestion

Mouth

Excessive thirst
Loss of taste
Strange taste
Bad Breath
Lip ulcers or lesions
Dry/cracking lips
Tongue pain
Bleeding gums
Receding gums
Tooth pain
TMJ

Neck

Pain
Swollen glands
Lumps
Stiffness

Chest

Pain in chest
Tightness/pressure in chest
Heart palpitations
Shortness of breath
Painful-difficult breathing
Persistent cough
Frequent chest colds

Skin

Dry-flakey
Rashes
Blisters
Acne
Changing or bleeding moles
Response to insect bites

Digestion

Pain
Burning indigestion
Belching
Regurgitation
Vomiting
Excessive Gas
Heavy-Bloaty after eating
Hemorrhoids
Constipation
Diarrhea
Both constipation and diarrhea
Bloody stools

Urinary

Loss of urination control
Painful urination
Urine retention, dribbling
Day or Night time urination often
Blood in urine
Pain in kidney/groin area
Kidney/bladder infections

Muscles and Joints

Swelling in joints
Pain/ache in joints
Stiff Joints
Persistent muscle/bone pains
Tremors/tics in muscles
Muscle weakness/atrophy

Nerves

Loss of taste, smell or touch
Tingling sensations
Tremors in limbs
Uncoordinated muscle/limbs

Circulation

Varicose veins
Cold hands – feet
Swollen ankles
Calf pain
Puffy eyes

Female System

Irregular cycle
Heavy/prolonged bleeding
Missed menses
Painful menses
Spotting
Discharge
PMS Symptoms
Pregnant
Miscarriage
Infertility
Genital sores
Ovarian cyst
Fibroids

Breasts

Swelling
Redness
Lumps
Nipple discharge
Tenderness-pain

Male System

Prostate gland swollen/painful
Low sperm count
Low mobility
Genital sores or lesions
Genital discharge
Erection difficulty

Daily Routines:

Describe your activities from the time you wake up until you go to sleep. Include approximate times (eating, sleeping, exercise, work, activities). List any foods eaten on a regular basis.

Morning
Awaken
Breakfast
Activities

Mid-Day
Lunch
Activities

Evening
Dinner
Activities

Night
Activities
Bed time

List regular practices that are not included in the above schedule, e.g. exercise, meditation, spiritual practices, etc.

Are you sexually active? Y or N Frequency?

Other comments about daily routines:

Are there any routines around eating?

Any current or past problems with chronic eating disorders or other food related issues? Y or N

Allergies or Sensitivities: Do you have allergic reactions to any substances. Please list

General Health Habits:

1. How many cups of caffeinated beverages do you drink per day?

2. How many cups of decaffeinated beverages do you drink per day?

3. How much water do you drink per day?

4. How much exercise do you get per day/week? Length of time? Type of exercise.

5. Do you smoke?

6. Do you drink alcohol, how many glasses of alcohol per week? Type of alcohol?

7. Any current or past problems with addiction or substance abuse? Y or N
   Substance? Amount? When Quit?

Manas – Emotions Overview:

When I am feeling at ease and content, I would describe myself as:

	1=not much 5= a lot	How often do you experience this?
Enthusiastic	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr
Creative	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr
Courageous	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr
Perceptive	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr
Disciplined	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr
Logical	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr
Nurturing	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr
Patient	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr
Forgiving	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr
Calm/stable	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr

When I'm having a bad day, I'm challenged by:

	1=not much 5= a lot	How often do you experience this?
Worry	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr
Anxiety/fear	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr
Overwhelm	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr
"Spaceyness"	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr
Self-Destructive	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr
Anger/Rage	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr
Jealousy/Envy	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr
Being critical	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr
Lethargy	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr
Sadness	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr
Depression	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr
Greediness	1 2 3 4 5	3x/wk 1x/wk 1x/mo 1x/yr

Predominant Negative Emotions (assess those valued from 3 to 5)

Doshic Imbalances: (V P K)

Notes:

Summary of Symptoms

This is for all significant symptoms listed on the review of Symptoms form. Describe all symptoms here that occur infrequently, but are of concern to the client. If the symptom occurs less than 1X per month and has an intensity of 1-3, it should be briefly described on this sheet.

1. Symptom (from Review of Symptoms form)

   Description:

   Frequency (1x per month)

   Intensity (1-3)

2. Symptom (from Review of Symptoms form)

   Description:

   Frequency (1x per month)

   Intensity (1-3)

3. Symptom (from Review of Symptoms form)

   Description:

   Frequency (1x per month)

   Intensity (1-3)

4. Symptom (from Review of Symptoms form)

   Description:

   Frequency (1x per month)

   Intensity (1-3)

5. Symptom (from Review of Symptoms form)

   Description:

   Frequency (1x per month)

   Intensity (1-3)

6. Symptom (from Review of Symptoms form)

   Description:

   Frequency (1x per month)

   Intensity (1-3)

Symptom History:

1. Symptom:

   Frequency of occurrence:

   Duration of episode:

   Intensity (Rate the discomfort from 1-10 where 10 is worse):

   When did it begin:

   Life events that parallel onset of symptoms:

   Related problems (physical, structural, emotional, environmental):

   Has this condition been evaluated? If so, by whom:

   Treatments received:

   What makes the condition better or worse:

Notes:

2. Symptom:

   Frequency of occurrence:

   Duration of episode:

   Intensity (Rate the discomfort from 1-10 where 10 is worse)

   Life events that parallel onset of symptoms:

Related problems (physical, structural, emotional, environmental):

Has this condition been evaluated? If so, by whom:

Treatments received:

What makes the condition better or worse:

Notes:

3. Symptom:

   Frequency of occurrence:

   Duration of episode:

   Intensity (Rate the discomfort from 1-10 where 10 is worse)

   Life events that parallel onset of symptoms:

   Related problems (physical, structural, emotional, environmental):

   Has this condition been evaluated? If so, by whom:

   Treatments received:

   What makes the condition better or worse:

4. Symptom:

   Frequency of occurrence:

   Duration of episode:

Intensity (Rate the discomfort from 1-10 where 10 is worse)

Life events that parallel onset of symptoms:

Related problems (physical, structural, emotional, environmental):

Has this condition been evaluated? If so, by whom:

Treatments received:

What makes the condition better or worse:

Notes:

5. Symptom:

Frequency of occurrence:

Duration of episode:

Intensity (Rate the discomfort from 1-10 where 10 is worse)

Life events that parallel onset of symptoms:

Related problems (physical, structural, emotional, environmental):

Has this condition been evaluated? If so, by whom:

Treatments received:

What makes the condition better or worse.

Notes:

6. Symptom:

   Frequency of occurrence:

   Duration of episode:

   Intensity (Rate the discomfort from 1-10 where 10 is worse)

   Life events that parallel onset of symptoms:

   Related problems (physical, structural, emotional, environmental):

   Has this condition been evaluated? If so, by whom:

   Treatments received:

   What makes the condition better or worse:

Notes:

Ayurvedic History

1. Describe your appetite | Short-Term | Long-Term | VPK

Hunger level	Variable/strong/low	Variable/strong/low
Typical quantity	Small, medium, large	Small, medium, Large
Frequency	Regular, irregular	Regular, irregular
Reaction to missing Meals	Anxious, lightheaded irritable, not significant	Anxious, lightheaded irritable, not significant

2. Describe digestion after eating | Short-Term | Long-Term | VPK

After eating Response	Gas, pain, bloat, heartburn, indigestion Heavy, sluggish, sleepy	Gas, pain, bloat heartburn, indegestion Heavy, sluggish, sleepy
Timing of response	1 to 2 hrs after eating Immediately after eating Other	1 to 2 hours after eating Immediately after eating Other

3. Describe trigger foods that cause problems:

4. Describe your elimination patterns, specifically bowel movement patterns

5. Short-Term Long-Term VPK

Frequency: times Per day	1x, 2x per day or more Regular, irregular	1x, 2x per day or more regular, irregular
Consistency	Dry, pellets, loose, unformed, formed mucousy, soft	Dry, pellets, loose unformed, formed mucousy, soft
Level of comfort	Straining, burning, slow, ease, no problem	Straining, burning, slow, ease, no problem
Stool Density	Float, Sink, Scatter	Float, sink, scatter

6. Describe your weight pattern over time and circle what best which one fits best for you?

   Weight patterns: Thin, yo-yo, easy to loose, variable, moderate, steady, Slow to gain with age, stocky, heavy, hard to loose

7. Do you tend to feel warm or cold more often?

8. What climate do you prefer? Tropical, cool/rainy, desert, moist, dry

9. Describe your sweating pattern? Hardly any, medium, profuse, some, odor of sweat? Hardly any, potent,

10. Describe qualities and condition of skin?

11. Condition of skin: Dry, variable, somewhat oily, damp

12. What skin irritations? Dry, rashes, acne, wet rashes/blisters

13. List any other skin patterns?

14. Describe your menstrual pattern. If menopausal, describe patterns when still menstruating? Circle which best describes your cycles.

Regularity: Irregular, variable, regular
Quality of flow: Light, variable, moderate, heavy
Level of discomfort: Painful, moderate, painless

15. How many days of cycle and flow?

16. Describe PMS symptoms?

17. Describe your sleeping patterns.

Type of sleep: Light, medium, easy
Ease in falling asleep: Variable, medium, easy
Ease in waking up: Easy, medium, with difficulty
Dream patterns: Flighty, intense, flowing

Ayurvedic History

Manas-personality : (Combine with Manas-Emotions to assess manas prakruti).

1. Do you find yourself most often a leader, follower, or one who goes off on your own? Do others place you in leadership roles, do you prefer a supportive role in groups? State the present and past attributes?

2. How do you react to stress? Overwhelm, scatter. Irritable, rise to challenge. What kinds of things generate stress? State the present and past experiences.

3. How are you at decision making? Fast, slow, indecisive, often or easily change mind once decided? Has it always been this way

4. Are you more like a bumblebee, a bull or a turtle? Describe each and have them tell you how they are like the one they chose? Past and present.

5. Describe your approach to projects. Beginning, finishing, number of projects going at one time and has it always been this way?

6. Describe the client's overall quality of voice and manner of speaking? Fast, rambling, storyteller, clear, concise to the point, slow, well thought out, quiet.

Ayurvedic Physical Assessment

Face	VPK	Oval, angular, square, round
Facial Energy	VPK	Delicate, subtle, passionate, Intense, soft, sweet
Eyes	VPK	Small, deep, set large, moist
Nose (size)	VPK	Small, medium, large
Nose (bridge)	VPK	Narrow, medium, wide
Lips	VPK	Thin, medium, thick
Neck	VPK	Long, medium, short
Hair traits	VPK	Course, dry, kinky, thin, fine, curly, early grey, thick, oily, straight, wavy
Skin Thickness	VPK	Thin, medium, thick
Skin Condition	VPK	dry, rough, wrinkles, slightly Oily, smooth
Complexion	VPK	Lacks luster, pale, ruddy Rose, radiant
Physique	VPK	Slight, moderate, stocky, irregular, shapely
Bones	VPK	Narrow, moderate, stocky
Palm of hand	VPK	Square, rectangular
Fingers	VPK	Long, narrow, medium, short, thick

Physical Exam

1. Viatal signs:

Blood Pressure Pulse

Height Weight

Respiration

Describe breathing pattern (deep, shallow, erratic, etc.)

2. Tongue Diagnosis

Observations

Shape: thin, small, long, medium, pointed, large, round, thick

Color: grey, pale, brown, pink, red, purple, pale, white

Moisture: dry, moist

Other: froth, scallops, tremors, bumps, cracks

3. Pulse Diagnosis

Deep pulse with or without pattern, irregular, regular
Strength weak, intermediate, strong
Movement fast, snake-like, jumpy, frog-like, full, swan-like

Superficial pulse with or without pattern, irregular, regular
Strength weak, intermediate, strong
Movement fast, snake-like, jumpy, frog-like, full, swan-like