Ayurvedic Intake Questionnaire

Name____ Date____________________

Age _________ Height_________ Male / Female Married / Single / Divorced

Weight_________ Weight (past) ________ Occupation____

Date of birth __________Time of birth__________ Place of birth____

Address____State_______Zip__________

Phones (home, cell, work)____

Email____

Why are you interested in an Ayurvedic consultation?

How did you hear about me?

Please describe your present health problems and their duration.

1. -- --------

2.………...

3.………...

4.………...

5.………...

How long have you had the chronic conditions about which you are consulting us?
☐ Less than 6 months ☐ 6 months to 2 years ☐ 2 to 5 years ☐ More than 5 years

How has your health problem progressed since it began?
☐ Stable ☐ Gradually improving ☐ Rapidly improving ☐ Fluctuating
☐ Gradually worsening ☐ Rapidly worsening

Please explain the overall intensity of your symptoms:
☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

How often are you having pain or discomfort?
☐ Daily ☐Less than once a week ☐ Several times per week ☐Several times a day ☐Most or all the times

Do you take any nonprescription drugs or vitamins or any other supplement Please list all of the them-----------------
-- --------------
--- ----------------------

Are you currently under the care of family physician or any other health professional?
If yes, mention details……………………………………………………………………………………...................

Are you currently taking any medications and/ or receiving any medical treatment for your health condition?
If so, please list all medications/ treatments and their dosage.

Do you have any past medical history or problem? (any other illness ,trauma, emotional stress addictions drug abuse or anything else to help us clearly understand your health condition)

Is there a family history of this health problem?
☐ Yes ☐ No If yes, please specify…………………………………………………………………………

Concern	Myself	Father	Mother	Brothers	Sisters	Spouse	Child	Other
Age (if living)								
Age (at death)								
Cause of death								
Anemia								
Cancer								
Diabetes								
Epilepsy								
Glaucoma								
Heart disease								
High blood pressure								
Hay fever								
Hives								
Kidney disease								
Mental disease								
Rheumatic arthritis								
Tuberculosis								
Syphilis								
Stroke								
Others								

Any other Family illnesses or concerns

Health as a child: ☐ Good ☐ Fair ☐ Poor

Childhood illnesses:
☐ Scarlet Fever ☐ German measles ☐ Measles ☐ Mumps ☐ Bronchial problems
☐ Rheumatic Fever ☐ Diphtheria ☐ Other……………………………………………….

Immunizations/ Vaccinations
☐ Smallpox ☐ Polio ☐Typhoid ☐Mumps ☐Tetanus ☐ Influenza ☐ other

Any vaccination reaction……………………………………………………………………………….

Daily Routine (Dinacharya)

Do you get up early? ☐ Yes ☐ No At what time?.........................

Do you go to bed early? ☐ Yes ☐ No At what time?.........................

Do you sleep in the daytime? ☐ Yes ☐ No

How do you generally feel on arising in the morning?
☐ Fresh and rested ☐ A little tired ☐ Moderately tired ☐ Fairly tired

In what direction does your head point during sleep?
☐ North ☐ South ☐ East ☐ West
☐ Northeast ☐ Northwest ☐ Southeast ☐ Southwest

How is your sleep?
☐ Sound, normal duration ☐ Light, interrupted ☐ Too little sleep
☐ Too heavy and/ or too long ☐ Difficulty falling asleep ☐ Difficulty waking up
☐ Awaken too early ☐ Frequently nightmares

What is your sleep position?
☐ On back ☐ On tummy ☐ Left side ☐ Right side ☐ Other…………………………

How regular is your daily routine? (For example, do you go to bed early, eat your meals on time, exercise reg.?)
☐ Very regular ☐ Somewhat regular ☐ Irregular

Describe your bowel movements:
☐ Once every 2-3 days ☐ Once daily ☐ 2-3 times per day
☐ First thing in the morning ☐ Late in daytime ☐ Immediately after meals
☐ Immediately after dinner ☐ Need laxative daily ☐ Other. Pls specify:

Bowel nature: ☐ Soft ☐ Medium ☐ Hard

Bowel Movement associated with ☐Pain ☐Gas ☐Blood ☐ mucous ☐ Foul smell ☐ Other

Do you delay or suppress any of the following?
☐ Sleep ☐Bowel movements ☐ Gas ☐ Urination ☐Yawning ☐ Burping
☐ Thirst ☐Breathing ☐ Semen ☐ Hunger ☐ Sneezing ☐ Cry, tears

Do you travel a lot? ☐ Yes ☐ No

Do you oil massage daily Yes No

Exercise

How often do you exercise?
☐ Weekly once ☐Weekly twice ☐Weekly thrice ☐ Weekly four times ☐ Every day ☐Not at all

How long do you exercise?...What type of exercise?...

Is your exercise: ☐ Vigorous ☐ Moderate ☐ Light Type of exercise………………………………..

Eating Habits

DO YOU EAT THE FOLLOWING FOOD GROUPS

Food groups	Daily	Weekly	Monthly	Never
Grains/ Cereals				
Vegetables				
Fruits				
Dairy				
Eggs				
Poultry				
Meat				
Seafood				
Sugar/ Honey				
Desserts				
Juices				
Other				

Please explain your typical food habits:

Breakfast………………………………………………………………………………………………………

Lunch…….

Dinner……

Snack…….

Do you eat between meals? □ Yes □ No

Do you eat your meals on time: □ Yes □ No

Which is your main meal? □ Breakfast □ Lunch □ Dinner

Rate your digestion: □ Good □ Fair □ Fair

How much water do you drink per day: None / 1-2 glasses / 3-4 glasses / 5-6 glasses / 7+ glasses

My eating habits include:
□ Eat with full attention on food □ Talk or converse a lot while eating □Eat very fast
□ Watch television while eating □ Never sit to eat

Describe your diet: □Vegan □ Lacto-vegetarian □ Ova-lacto-vegetarian □ Other………..

Non-vegetarian:
□ Beef □ Pork □ Chicken □Turkey □ Seafood □ Eggs □ Other…………..

Have you experienced any changes in your sense of taste? (Choose one)
□ Loss of taste □ Sweet taste in mouth □ Sour taste in mouth
□ Pungent taste in mouth □ Bitter taste in mouth

What taste(s) do you like or crave? □Sweet □Salty □Sour □Bitter □Hot/ Spicy □Starches □Oily

Are there any particular foods that create discomfort when you eat them?
□ Sweet □ Salty □ Sour □ Bitter □ Astringent □ Dairy products (including cheese)

Miscellaneous

Do you practice any type of meditation? Please explain.

Do you practice any Yoga techniques? Please explain.

Which type of weather makes you feel most uncomfortable? ☐ *Cold* ☐ *Hot* ☐ *Cool and damp*

Are you allergic to any substances? Please specify: food, pollen, dust, etc. and any other allergic reactions?

Do you smoke cigarettes or others? ☐ Yes ☐ No
If yes, how many per day? ☐ ½ pack ☐ 1 pack ☐ 2 packs ☐ More than 2 packs

How often do you drink alcohol? Never / Less than once a week / About once a week / Several times a week / More than once a day: How much?...

How often do you drink caffeinated beverages (coffee, tea)? Never / one cup daily / 2-3 cups daily / 4-5 cups

How would you rate your usual energy level?
☐ Very high ☐ High ☐ Moderate ☐ Low ☐ Very low

Do you often experience any of the following?

☐ Worry ☐ Anxiety ☐ Fear or panic ☐ Loneliness
☐ Depression ☐ High stress level ☐ Lack of memory ☐ Light-headedness
☐ Lack of energy ☐ Suicidal tendency ☐ Anger ☐ Irritation

Social History

How are your family relationships? ☐ excellent ☐ Good ☐ Fair ☐ Poor

How is your social life? ☐ excellent ☐ Good ☐ Fair ☐ Poor

How is your mental status: ☐ excellent ☐ Good ☐ Fair ☐ Poor

How is your career? ☐ Love it ☐ Like it ☐ Can stand it ☐ cannot stand it

How purposeful is your life? ☐ Completely ☐ somewhat ☐ Neutral ☐ Not happy

Rate your spiritual life: ☐ fully satisfying ☐ Somewhat Satisfying ☐ Neutral ☐ Empty

As a child, did you experience any abuse or trauma? ☐ None ☐ Emotional ☐ Physical ☐ Sexual ☐ Verbal
☐ Other (please specify)………………………………………………………………………………

For Men Only: Do you have any problems?

☐ Hernias ☐ Sexually active ☐ Sexual difficulties ☐ Problem starting/ stopping urination
☐ Libido ☐ Erection problems ☐ Prostate problems ☐ Discharge or sores
☐ Birth control ☐ Venereal disease ☐ Testicular masses ☐ Tenderness, enlargement of breast

For Women Only: Age menses began:…………………………
Which of the following describes your menstruation? (you may choose more than one)
☐ Regular ☐ Irregular ☐ Too frequent ☐ Absent ☐ Ceased due to menopause

How many days does your menstrual period last?
□ 0-4 days □ 5-7 days □ More than 7 □ Spotty irreg. throughout the month
□ Other (please specify):…………………………………………………………………………….

How is your menstrual flow? □Normal □Heavy □Light □ Abnormal vaginal discharges

Associated symptoms (before or during menstruation):
□ None □ Pain □ Fluid retention □ Migraine □ Depression
□ Acne □ Tension □ Nightmares □ Frustration □ Loneliness

Do you have any discharge outside of your menstrual period? □ Yes □ No

Do you ever experience pain during intercourse? □ Yes □ No

Do you have any sexual difficulties? □ Yes □ No
If yes, please explain……………………………………………………………………………………

Are you pregnant now? □ Yes □ No □ Don't know

Do you take contraceptive pills or use other devices? □ Yes □ No If yes, please explain………………..

Number of previous pregnancies : 0 1 2 3 4 5 6 7 or more

Do you have any history of abortion miscarriage, etc.? If yes, explain……………………………………………….

How many children do you have?........................... Children's ages:…………………………………………………

Do you self-exam your breasts regularly? □ Yes □ No

Do you experience any problems in breasts? □ Pain or tenderness □ Lumps □ Nipple discharge □ other

Other comments

I understand that this is an educational Ayurvedic consultation for the purpose of helping me to improve my health and wellness I understand this does not include medical diagnosis or medical treatment and is not a substitute for medical care. It is not an agreement for on going care.

-- -------------------------------------
Client signature date