vibrant soulful
yoga and ayurvedic wellness
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Confidential Client Health Intake Form

Name | Date | Age

Date of Birth | Email

Home address

City | State | Zip

Daytime Phone | Evening Phone

Referred by | Family Phyisician

Birthplace | Place of childhood

Occupation | Relationship Status

Would you like to be added to our newsletter? ❑ YES ❑ NO

Your Goals
What would you like to achieve or change in terms of your current health and wellness?

What would you like to get out of an Ayurvedic wellness consultation?

Primary Concerns
What are your main health concerns at this time? Order by importance.

Are you currently under the care of a licensed health care provider or any other health care provider?

❑ YES ❑ NO If so, for what reason(s)?When was your last physical exam?

Personal History

Do you or your family members have a history of:

	Myself	Maternal	Paternal		Myself	Maternal	Paternal
Allergies to food/drugs				Heart Surgery			
Anemia				Hepatitis A			
Arthritis				Hepatitis B			
Asthma/Pneumonia/TB				Hepatitis Non A/Non B			
Blood Pressure, High/Low				HIV Exposure			
Cancer				Implant, Prosthesis			
Chemotherapy/Radiation				Kidney or Bladder Disease			
Chest Pain/Angina				Mononucleosis, Jaundice, Gallstones			
Contact Lenses				Pain in Ear, Ringing in Ear			
Dental Treatment Complications				Popping, Clicking, Locking of Jaw			
Diabetes				Prolonged bleeding when cut			
Dizziness				Psychiatric Treatment			
Drug/alcohol abuse				Rheumatic Fever			
Epilepsy, Convulsions, Seizures				Shortness of breath			
Fainting Feet or Ankles Swelling				Stroke/Cerebrovascular Accident			
Glaucoma/Eye Surgery				Thyroid Disease or Medication			
Heart Attack				Ulcers, Intestinal Bleeding			
Heart Disease/Murmur				Venereal Disease			

History of any other diseases or problems

List other illnesses, surgeries, diseases, injuries, trauma, emotional stresses, mental stresses, lifestyle conditions, addictions, alcohol, drug use, changes of weight, etc.

Family history of any other diseases or problems

Current Medications, Herbs, or Supplements

What medications, herbs or supplements are you currently taking? Please list the dosage and how long you have been taking it Please include significant remedies that you have stopped taking such as birth control or hormone therapy.*

Please check any recent changes or concerns in the following areas:

- ❏ Dryness (skin, lips, hair, nails, colon, cough, etc.
- ❏ Insomnia
- ❏ Gas/bloating
- ❏ Constipation
- ❏ Muscle twitching, cramping, numb, weak
- ❏ Joint pain, cracking
- ❏ Stiffness
- ❏ Shifting, tearing pain
- ❏ Cold extremities
- ❏ Restlessness
- ❏ Worry, fear, anxiety
- ❏ Diarrhea, loose stool
- ❏ Nausea or vomiting
- ❏ Migraines
- ❏ Rashes, acne, hives
- ❏ Bruises easily
- ❏ Excess thirst
- ❏ Burning, sharp pain
- ❏ Bleeding
- ❏ Tenderness to the touch
- ❏ Excess body heat
- ❏ Interrupted sleep
- ❏ Anger, rage, envy, judgement, critical
- ❏ Congestion
- ❏ Food/respiratory allergies
- ❏ Edema
- ❏ Heaviness
- ❏ Dull, vague pain
- ❏ Cold, clammy hands
- ❏ Frequent urination
- ❏ Excess oily skin
- ❏ Excess sleep
- ❏ Depression, attachment, mental lethargy
- ❏ Coating on tongue
- ❏ Low fever
- ❏ Excess sleep
- ❏ Aches/pains
- ❏ Malaise
- ❏ Lethargy
- ❏ Lack of energy
- ❏ Lack of taste, appetite
- ❏ Indigestion
- ❏ Sinking stool
- ❏ Energy level
- ❏ Throat
- ❏ Eyes
- ❏ Ears
- ❏ Chest
- ❏ Lungs
- ❏ Heart
- ❏ Circulation
- ❏ Urine (cloudy, clear, burning odor, etc.)

Vitals

Height Weight Weight change last year? ❏ YES ❏ NO Ideal weight:

Body temperature ❏ warm ❏ cool ❏ variable ❏ steady

Cold hands and feet? ❏ YES ❏ NO Easily flush? ❏ YES ❏ NO

Do you overheat? ❏ YES ❏ NO Blood pressure ❏ LOW ❏ HIGH ❏ NORMAL

Regular Practices

Exercise	Describe	Frequency
Spiritual Practice	Describe	Frequency
Travel	Describe	Frequency

Daily Schedule

What are your habitual activities from the time you wake up until you go to sleep? Include meal times, sleep, exercise, work and any other regular activities.

		Time	Activities
Morning	Wake up		
	Breakfast		
	Activities		
Afternoon	Lunch		
	Activities		
Evening	Dinner		
	Activities		

Other Habits

Do you use tobacco?	❑ YES ❑ NO	Years?	Amount?
Do you drink alcohol?	❑ YES ❑ NO	What types?	How often?
Do you use recreational drugs?	❑ YES ❑ NO	If so, what type(s)?	How often?
Do you drink coffee?	❑ YES ❑ NO	Cups/day?	
Do you drink caffeinated/herbal tea?	❑ YES ❑ NO	Cups/day?	
Do you drink sugary beverages or soda?	❑ YES ❑ NO	If so, what type(s)?	Cups/day?
Do you drink water daily?	❑ YES ❑ NO	Glasses/day?	
Any other habitual substances?	❑ YES ❑ NO	Specify	

Diet and Daily Nutrition *What types of food do you eat on a daily basis?*

Breakfast

Lunch

Dinner

Snacks

Allergies and Sensitivities
List any allergic reactions to any substances (including foods, pollen, medicine, environmental) or any foods that give you unwanted symptoms

Elimination
How many bowel movements do you have in a day? ❑ 1 ❑ 2 ❑ 3 ❑ 4

How would you describe your bowel movements? ❑ loose ❑ normal ❑ hard/dry ❑ tarry

Do your stools ❑ float ❑ sink ❑ have bad odor ❑ have no odor ❑ display blood?

Do you rely on ❑ enemas ❑ laxatives ❑ purgatives for bowel elimination?

Any other digestive problems?

Any current or past chronic eating disorder or other food related issues ❑ YES ❑ NO

Appetite (AGNI)

❑ VARIABLE: Sometimes I'm not hungry, but if I don't eat, I get low blood sugar, light headed, dizzy.

❑ SHARP: Ravenous. I have to eat right away when I'm hungry or I get irritable.

❑ DULL: I like to eat, but if I skip a meal, it's not a big deal.

❑ SAMA: Steady, consistent appetite at meal times. I feel satisfied after a meal.

Time of day you're most hungry:

Energy

❑ High ❑ Low ❑ Variable ❑ Dips How much energy do you have on a scale of 1 - 10?

Does it change during the day? ❑ YES ❑ NO | Do you take naps? ❑ YES ❑ NO | How often?

Sleep Patterns

What time do you regularly go to bed? What time do you regularly fall asleep?

Is it easy to fall asleep? ❑ YES ❑ NO

Is it easy to get up in the morning? ❑ YES ❑ NO

Do you get hot while sleeping? ❑ YES ❑ NO

Do you wake during the night? ❑ YES ❑ NO
How often? What time?

Describe any sleep issues you have:

If you have sleep issues, what do you think is the primary cause?

Female Reproductive

Do you menstruate? ❑ YES ❑ NO Age of onset of menses _____

What is the length of your cycle? _____ days Duration of bleeding? _____ days

Is your flow ❑ Heavy ❑ Medium ❑ Light ? Is the blood ❑ Dark ❑ Medium ❑ Light ?

Are you pregnant? ❑ YES ❑ NO ❑ POSSIBLY How many pregnancies have you had?

Do you or have you recently used contraceptives? ❑ YES ❑ NO If yes, which types?

Are you in menopause? ❑ YES ❑ NO

Are you currently experiencing, or have you experienced any of the following?

- ❑ Discharge? Color _____
- ❑ Genital herpes
- ❑ Cervical dysplasia
- ❑ Endometriosis
- ❑ Uterine cysts
- ❑ Fibroids
- ❑ Vaginal itching
- ❑ Anemia
- ❑ Pelvic inflammatory disease
- ❑ Infertility
- ❑ Hysterectomy
- ❑ Pain with intercourse
- ❑ Tubal ligation
- ❑ Mastectomy
- ❑ Lumpectomy
- ❑ Vaginal infection

Do you experience premenstrual PMS symptoms? ❑ YES ❑ NO
How many days before your cycle do symptoms begin to manifest?

If you have PMS, which symptoms apply to you?

- ❑ Anxiety
- ❑ Nervousness
- ❑ Mood Swings
- ❑ Nervous tension
- ❑ Craving for sweets
- ❑ Increased appetite
- ❑ Palpitations
- ❑ Fatigue
- ❑ Dizziness
- ❑ Headaches
- ❑ Bloating
- ❑ Weight gain
- ❑ Water retention
- ❑ Depression
- ❑ Poor memory
- ❑ Grief
- ❑ Confusion
- ❑ Insomnia
- ❑ Lower back pain
- ❑ Abdominal pain
- ❑ Joint pain

If you have menopausal symptoms, please list your major symptoms:

Do you have any other gynecological issues?