Health Information and History

Your Name last _____ first _____ Date _____

Home Address _____

City _____ Provence/ State_____ Postal / Zip code _____

Home Phone _____ Cell Phone _____

Date of Birth_____Email _____

Age _____ Occupation _____ Marital Status _____

Children & Ages _____

Family Physician/ Primary Care Provider _____ Phone _____

Address _____

Please describe the present symptoms with which you are concerned and for how long have you have been experiencing them? _____

_____

_____

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

_____

_____

Are you currently under a physician's care for a specific medical problem or condition? Yes __No ___

If yes, for what:_____

When was your last physical examination _____ Blood Pressure _____ Cholesterol _____

Height _____ Weight _____ Weight Changes _____

What prescription drugs or medications are you currently taking? (how often, how much, how many years)_____

_____

_____

Herbal & vitamin supplements (what, how often, how much, how many years) _____

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) _____

Surgeries you have had? Dates ? _____

_____

Do you or your family members have a history of (check the boxes that apply)

	Myself	Family Member			Myself	Family Member	
		Maternal	Paternal			Maternal	Paternal
Allergies to Food	☐	☐	☐	Stroke	☐	☐	☐
Allergies to Drugs	☐	☐	☐	Cerebro Vascular 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 When Cut	☐	☐	☐
Heart Attack	☐	☐	☐	Psychiatric Treatment	☐	☐	☐
Heart Disease	☐	☐	☐	Venereal Diseases (STDs)	☐	☐	☐
Heart Surgery	☐	☐	☐	HIV Exposure	☐	☐	☐
Rheumatic Fever	☐	☐	☐	Sleep Disorders	☐	☐	☐

History of Any Other Diseased Or Problems? (Please list any other illnesses, surgeries, diseases, injuries, trauma, emotional stresses, mental stresses, life-style conditions, addictions, changes of weight, or anything else to help us better understand you.

_____

_____

_____

What is your general routine for taking care of yourself? (e.g. exercise, relaxation) _____

_____

_____

_____

FEMALES: Are you pregnant? _____

Number of Months _____

Number of previous births _____

Difficult past pregnancies _____ Complications _____

Birth Control: ☐ yes ☐ no What Type _____ How long _____ ____

Cycles: ☐ regular ☐ irregular Length of Cycle _____ Flow: ☐ heavy ☐ med ☐ light

Pain and/or difficulty or other symptoms during cycle _____

Yeast infections (frequency, duration) _____

Urinary tract infection (UTI) (frequency, duration) _____

Menopausal stage / symptoms _____

_____

MALES: Prostate Condition _____

Other _____

_____

Application for Services

Privacy Policy

As an integrative facility, please be advised that your practitioner may consult with co-practitioners regarding your wellness and treatment protocols to ensure that you receive the most comprehensive treatment. By signing your name below, you agree to have the information in your files shared among those practitioners relevant to your treatment strategy only.

An Educational Ayurvedic Consultation is to:

- Determine your constitution
- Identify and assess any current imbalances that may exist
- Address your cares and concerns by developing a collaborative plan
- Provide information and guidance relevant to helping you come to balance

I Agree to: (Please check boxes you agree to)

- ☐ Participate in the development of my health and wellness plan
- ☐ Notify my primary care provider, if under their care, of my intention to begin a new health and wellness plan
- ☐ Discontinue any or all of the health and wellness plan elements if any discomfort occurs, and to notify my consultant and primary care provider of them

Services Not Offered or Available:

- Diagnosis of pathological or medical conditions
- Treatment for pathological or medical conditions
- Prescription of prescription drugs or medicine

I have read all the information contained in this package, answered all questions and have completed the medical information and history. By signing, I acknowledge that this is an Ayurvedic consultation for the purpose of providing an educational opportunity for me and this does not include medical diagnosis or medical treatment and is not a substitute for medical care.

_____	_____	_____
(Client/Guardian Signature)	(Printed Name)	(Date)

Please return the Application for Services and Health Information and History forms prior to your appointment.