MANJIRI NADKARNI, M.D. (Ayu.), R.H.N, C.B.A.C.

Ayurvedic Physician, Registered Holistic Nutritionist, Certified Base Allergy Consultant

Intake Form

Name: ______________________________ Sex: M/F

D.O.B: ______________ Age: ______________

Marital Status: ______________ Children(#/ages): ______________

Address: ______________________ City : ______________

Postal code: ________

Email: ______________ Contact No: ______________

Occupation: ______________ Family Physician: ______________

OBJECTIVES

What is your health and wellness goal? Specify things you want to achieve or change?

1. ______________________________
2. ______________________________
3. ______________________________

HEALTH REVIEW

What are your main health concerns/ complaints? (According to priority & duration)

____

____

____

____

When and how did this condition begin?

____

____

Has anything changed or worsened in the past 6 months?

____

____

Are you currently receiving care from any health professionals? For which condition(s)?

____

When did you last visit your family doctor?

____

Have you ever been diagnosed with an illness? Yes ☐ No ☐ If so, please specify

____

____

Have you ever been hospitalized? Yes ☐ No ☐ If yes, what reason?

____

Have you ever had surgery to remove your…. Gall bladder ☐ Tonsils ☐ Appendix ☐

____

Have you experienced any major trauma you have sustained in the past 5 years?
(Accidents, injuries, physical, emotional, spiritual)

____

Do you have any infectious diseases/history of childhood infections? If yes, please specify

____

Do you have any known anaphylaxis (life threatening allergies), allergies or sensitivities (drugs, pollen, foods)?
Yes ☐ No ☐ If yes, please specify

Have you taken antibiotics over the past 5 years? Yes ☐ No ☐

Do you take birth control pills? Yes ☐ No ☐

Have you had any dental work? Anaesthesia ☐ Dental Fillings ☐ Root Canal ☐ Please specify

History of any vaccinations? DPT ☐ MMR ☐ Polio ☐ Small Pox ☐ Flu Shot ☐ Any other, Please specify

Are you currently taking any medications/ supplements? (Include all prsecription medication, OTC, vitamins, minerals, herbal or homeopathic remedies?

Medication/ Supplement	Name	Brand Name	Dose	Frequency

FAMILY HISTORY : Please circle relevant

Allergies/ Alcoholism/ Arthritis/ Asthma/ Autoimmune Disorder/ Cancer/ Diabetes/ Drug Abuse/ Heart Disease/ Hypertension/ Intestinal Disease/ Kidney disease/ Anxiety/ Depression/ Bipolar/ Skin disorders

Any other please specify

FEMALES:

Are you/could you be pregnant? Yes ☐ No ☐ LMP:
Are your menses regular? Yes ☐ No ☐
Have you noticed any changes in menses, for example the frequency, duration, flow, clotting or other changes? Yes ☐ No ☐
If so, please specify ____________________
Do you suffer from PMS symptoms? If so, please specify
____
Do you or have you recently used contraceptives? Yes ☐ No ☐ If yes, which ones?
OCP ☐ IUD ☐ Condoms ☐ Diaphragm ☐ Rhythm ☐ Spermicidal jelly ☐
How many pregnancies have you had?__________Births? __________ Miscarriages ? __________Premature births? Abortions?__________
Date and result of your last pap smear: ____________________
Are you pre-menopausal? Yes ☐ No ☐ Post-menopausal? Yes ☐ No ☐
Are you experiencing any menopausal symptoms? Yes ☐ No ☐
If yes please specify ____________________
Do you have any other gynecological issues? ____________________
Have you had a bone density test? Yes ☐ No ☐

MALES:

Have you experienced any prostate problems(eg. Frequent urination, discomfort during urination)?
Yes ☐ No ☐ If yes please describe

PERSONAL HEALTH REVIEW

Have you gained/ lost weight recently (past 1 yr)? How much?

Do you wish to gain weight? ☐ Lose weight? ☐ How much?

By when do you wish to reach your gal weight?

What is your main motivation to reach your goal weight?

Are you a smoker? Yes ☐ No ☐ If Yes, Years: Amount:

Did you smoke in the past? Yes ☐ No ☐

Do you use recreational drugs? Yes ☐ No ☐ If Yes, What type?

Have you been treated for drug/alcohol dependency? Yes ☐ No ☐

Do you exercise regularly? Yes ☐ No ☐ Type?

Frequency:

On a scale of 1 (low) to 10(high), how would you describe your energy level?

Do you experience any lulls or highs in your energy levels throughout the day?

How often do you have a bowel movement?

Descrive your bowel movements? Loose ☐ Normal ☐ Hard ☐ Tarry ☐

Do your stools: Float ☐ Sink ☐ Bad odor☐ No odor ☐ Display blood ☐

Do you strain to have a bowel movement? Yes ☐ No ☐ Occasionally ☐

Related to particular food/circumstances?

Do you have loose bowel movements? Yes ☐ No ☐ Occasionally ☐

Related to particular food/circumstances?

Do you rely on: Enemas ☐ Laxatives ☐ Purgatives ☐ for bowel elimination?

If yes, how often? ________times/week .

Is there undigested food in your stools? Yes ☐ No ☐ Occasionally ☐

Do you use cosmetics on a regular basis? Yes ☐ No ☐

Do you use hair dyes/ hair color on a regular basis? Yes ☐ No ☐

Do you use scented moisturizers/ skin creams? Yes ☐ No ☐

Do you use scented fabric softener/ perfumes? Yes ☐ No ☐

Do you use harsh cleaning products like Windex etc.? Yes ☐ No ☐

Have you ever used pesticides in your lawn? Yes ☐ No ☐

Do you have any tattoos or piercings? Yes ☐ No ☐

Are you exposed to any other chemicals due to your job etc.? Yes ☐ No ☐

If yes, please specify ______________________________

Have you purchased a new car, a new home, new carpet, new pets in the past year? Yes ☐ No ☐

Have you experienced any emotional trauma that you suspect may have affected your physical self?

Yes ☐ No ☐ If yes, please specify ______________________________

Are you aware of the circumstances of your birth? (C-section, induced, forceps, long labor,jaundice)

Were you breastfeed as a baby? Yes ☐ No ☐

MIND AND EMOTIONS REVIEW:

What level of stress are you experiencing at this time? Please quantify on a scale of 1(low) to 10 (high):

1 2 3 4 5 6 7 8 9 10

What are the major causes of your stress? Rate all that apply on a scale of 1(low) to 10 (high)

Financial______ Career______ Personal______ Family______ Marriage______ Health______Spiritual ___
Unfulfilled expectations________ Other (please specify) ________________

How does your stress manifest itself ? ____

Do you use any coping mechanisms? ____

Do you get nervous easily? Yes ☐ No ☐

What feelings do you most often experience in your life? Joy ☐ Happiness ☐ Satisfaction ☐

Sympathy ☐ Worry ☐ Depression ☐ Anxiety ☐ Anger ☐ Sadness ☐ Fear ☐

Are you able to express your feelings and emotions easily? Yes ☐ No ☐

How many hours/day do you work? Do you work regular hours or shifts?

Do you enjoy your work? Yes ☐ No ☐

How many hours on an average do you sleep daily (include naps)

What time do you go to sleep? Awaken?

Do you have trouble falling asleep? Staying asleep?

Do you awaken feeling rested? Yes ☐ No ☐ Do you snore? Yes ☐ No ☐

DIETARY REVIEW:

How many times do you eat:

Main meals: ______________ Times of the day: ____________________________________

Snacks: __________________ Times of the day: ____________________________________

Do you eat meals: with family ☐ home alone ☐ on the run ☐ restaurant ☐ fast food ☐

Do you follow a specific diet? Yes ☐ No ☐ If yes please please specify:__________________

Do you now / have you ever followed a restricted diet/ have restrictions due to family members, roommates etc?____

Dietary preference: vegan ☐ vegetarian ☐ pescatarian ☐ meat eater ☐

How often do you eat meat: daily ☐ 3-5/week ☐ 1/week or less ☐

How often do you consume dairy products? daily ☐ 3-5/week ☐ 1/week or less ☐

What are your favorite foods? ____

How often do you eat them? ____

Do you avoid certain foods? Yes ☐ No ☐ If so, please explain

____

How many ½ cup servings of each do you typically eat in a day?

________Fruit: Fresh ☐ Dried ☐ Canned ☐

________ Vegetables: Cooked ☐ Raw ☐

________ Whole grains

________ Protein: Types ____

________ Dairy : Types ____________________

________ Other: Specify ____________________

Do you use indulge in sweets and desserts? Yes ☐ No ☐

How often? __________ times/ week How much?__________servings/day

How many teaspoons of sugar do you have in a day?____________________

Do you use artificial sweeteners? If yes what kind? ____________________

Do you crave any foods? If Yes what kinds? And at what time of the day?

____

____

To the best of your ability, please provide examples of your daily meals:

Breakfast: ____________________

____

Lunch: ____________________

____

Supper: ____________________

____

Snacks: ____________________

____

Do you use Aluminium pans/ Microwave on a regular basis? Yes ☐ No ☐

Please circle the appropriate word and indicate how many cups of the following do you drink per day

Water: Tap/ Filtered/Bottled		Cows Milk: skim, 1%, 2%,whole	
Coffee/ Decaf coffee/ Tea/Herbal Teas		Soft drinks: Regular/ Diet	
Fruit juice: Fresh/ Boxed		Alcoholic beverages	
Vegetable juice: Fresh/ Boxed		Other	

Waiver of liability:

I, the undersigned, hereby confirm that I am consulting with Manjiri Nadkarni, M.D.(Ayu.), R.H.N. , C.B.A.C. of my own free will. I understand that Manjiri Nadkarni is not a medical doctor and there will be no diagnosis made, no prescription given, but that she will offer an assessment of my general health and will make dietary, nutritional and supplemental recommendations to support my health. I understand the importance of frequent monitoring to revise the health protocol as required.

Signature: ____________________Date: __________

Print Name: ____________________

All case history notes and medical information recorded during the consultation are kept strictly confidential. Information contained herein will not be released to any person or agency except with your authorization or where required by law.