Health Information and History

CONTACT INFORMATION:

Client Name _____ Date _____

Home Address _____

Daytime Phone _____ Evening Phone _____ Cell Phone _____

E-mail _____

PERSONAL INFORMATION:

DOB _____ Time of Birth _____ Place of Birth: City _____ State/Region _____ Country _____

Age _____ Occupation: _____ Marital Status _____ Children & Ages: _____

Referred by _____ Family Physician _____

Primary Care Provider Name& Title _____ Phone _____

Address _____

OBJECTIVES:

Please check the items that reflect your main objectives:

Please note that **Ayurvedic Consultations do not include medical diagnosis and treatments**. If you are concerned about a medical condition or a latent or potential medical condition you should see a medical doctor.

[ ] 1. I would like an alternative approach to allopathic medicine for managing illness and disease ( )
[ ] 2. I would like to improve my general health and wellness and reduce my vulnerability to illness and disease
[ ] 3. I would like to improve my lifestyle and dietary practices to improve my health
[ ] 4. I would like to change my habits and behavioral patterns to improve my relationships with others
[ ] 5. I would like to manage stress, tension and worry to attain a more stable emotional nature

How would your life be different if you were to achieve these objectives to your satisfaction? _____

Are you currently under a physician's care for a specific medical problem? **(**If yes, for what) _____ _____
_____ _____
_____

CONCERNS: Please tell us your present concerns. How long have they troubled you? _____

_____

_____

_____

_____

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

_____

_____

_____

Last physical examination: Date _____ Blood Pressure _____ Cholesterol_____ BLOOD TYPE _____

Height _____ Weight _____ Weight Changes _____

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

Prescription:	Reason	Duration taken	Current dosage	Quantity per	Frequency per day	Before/after/during or between meals

Herbal/ vitamin supplements	Reason	Duration taken	Current dosage	Quantity per	Frequency per day	Before/after/during or between meals

History of Smoking:_____ Drinking alcohol: _____ Recreational / Non-prescription Drugs: _____

What surgeries/major accidents/major traumas have you had? (Include dates) _____

_____

_____

C) PERSONAL HISTORY:

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 Disease Or Problems? (Please list any other allergies, illnesses, surgeries, diseases, injuries, trauma, emotional stresses, mental stresses, life-style conditions, addictions, alcohol, drug abuse, changes of weight, or anything else to help us clearly understand your health condition)

FAMILY HISTORY: Any other family illnesses?

EXERCISE: Do you currently engage in any exercise or physical activity? __ If so, what type(s)? ___

Have you ever done Yoga postures before? _____ If so, what type(s), how often? _

FEMALES: Age of onset of menses _____ Are you pregnant? _____ Number of Months _____ Number of previous pregnancies ____

Difficult past pregnancies _____ Complications _____

Birth Control ☐ yes ☐ no What Type _____ How long _____ Date of Last Menstrual Period _____ Length of cycle ____

Cycles: ☐ regular ☐ irregular _____ Days between cycles _____ Flow: ☐ heavy, ☐ med, ☐ light Color of blood _____

Clots: ☐ yes ☐ no When _____ Pain and/or difficulty during cycle _____

PMS symptoms: _____

Any other symptoms during cycle: _____

Yeast infections: _____

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

Menopausal stage / symptoms: _____

MALES: Prostate Condition _____ Other _____

Check all that apply:

Category			
Digestion	[] Irregular with [] Bloating [] Gas/Flatulence [] Abdominal Discomfort [] Gurgling Intestines [] Breathlessness	[] Quick digestion with [] Acid Indigestion [] Heartburn [] Burning pain [] Still hungry after eating [] Nausea [] Vomiting	[] Slow digestion with [] Feeling of heaviness [] Lethargy [] Sleepy after eating [] Low energy after meals [] Excess mucous secretions
Appetite	[] Irregular [] Sometimes eats at midnight	[] Excess hunger [] Sharp hunger [] Desire to eat large amount of food [] Strong unbearable appetite [] Feels hypoglycemic	[] Emotional eating (No urge for food but still the person eats) [] Dull / No appetite
Cravings	[] Fried food [] Hot spicy food [] Meat or other protein	[] Sweets [] Cooling foods & drinks	[] Hot, sharp, dry & spicy food [] Wine or alcohol
Elimination	[] Tendency toward constipation [] Dry [] Irregular [] Defecates without satisfaction [] Passes gas during elimination	[] Loose stools [] Diarrhea	[] Mucous in stool
Pain (where, when, how often)	[] Shifting [] Tearing [] Moving [] Vague [] Throbbing [] Colicky [] Cutting [] Excruciating with breathlessness, fear and tachycardia	[] Burning [] Sharp [] Hot [] Migraine headaches [] Sucking pain with fever, nausea and irritability [] Intense pain	[] Dull [] Stable [] Deep dull aching pain [] Can sleep through the pain
Skin	[] Dry [] Cracked [] Rough [] Thin [] Discolored [] Patchy	[] Hives [] Rash [] Urticaria [] Acne [] Tender [] Warm/hot to touch [] Redness [] Boils [] Ruddy [] Itchy	[] Excess oily [] Thick [] Pallor [] Cold/clammy [] Lustrous
Sleep	[] Insomnia [] Need night light [] Restless [] Difficulty falling asleep	[] Interrupted sleep [] Must have complete darkness [] Needs to read/TV to sleep	[] Excess sleep [] Daytime napping [] Heavy sleeper [] Slow to awaken [] Hypersomnia
Seasonal Allergies	[] Breathlessness [] Wheezing [] Constricted Breathing	[] Rash [] Itching eyes [] Hives [] Irritation [] Inflammation	[] Runny nose [] Watery eyes [] Congestion
Food Sensitivity	[] Night shades [] Left-overs [] Dry fruits [] Raw food	[] Hot spicy foods [] Sour foods [] Fermented foods	[] Dairy products
Sweating	[] Scanty or no sweat	[] Excess [] Profuse with body odor	[] Cold/clammy
Muscle Reactivity	[] Twitching [] Cramping [] Weakness [] Numbness [] Tingling [] Spasms	[] Bruising [] Tenderness to touch [] Sore [] Excess heat	[] Tumors [] Cysts [] Growths [] Generalized weakness

Category			
Bone and Joints	[] Painful [] Popping [] Cracking [] Stiffness [] Loose [] Osteopenia [] Osteoporosis [] Medical fractures [] Scoliosis	[] Inflamed [] Hot / feverish [] Tender [] Inflammatory arthritis [] Osteomyelitis [] Bursitis	[] Swollen joints [] Bone tumors [] Bone spurs [] Osteosarcoma [] Non-inflammation with profuse infusion [] Sclerosis
Circulation	[] Cold extremities (hands, feet)	[] Burning hands / feet [] Bruises easily [] Tendency toward bleeding	[] Cold clammy hands [] Varicose veins [] Thrombotic element
Body weight	[] Variable [] Can't gain weight [] Thin or slender	[] Stable [] Tendency toward hyper metabolism	[] Tendency to easily gain weight [] Over-weight [] Obese [] Voluptuous [] Stout
General Symptomatology	[] Dry cough [] Ringing ears [] Light-headed [] Dryness: external/internal [] Hemorrhoids: external / non-bleeding [] Low back ache [] Irregular metabolism [] Dry mouth [] Receding gums [] Blackish brownish discoloration [] Fatigue [] Lack of power, tone & strength [] Paralysis [] Slipped disc [] Hernia [] Difficulty sweating [] Cold extremities (hands, feet)	[] Spontaneous bleeding [] Hyper-sensitive to smells [] Hair loss [] Excess thirst [] Hemorrhoids: internal / bleeding [] Hot flashes [] Tendency toward inflammatory conditions [] Acidic saliva [] Hyper acidity [] Yellowish discoloration [] Fainting [] High metabolism	[] Cold [] Cough [] Congestion [] Excess urination [] Frequent urination [] Fibrocystic [] Over salivation [] Edema [] Slow metabolism [] Albuminuria [] Lipoma(s) [] Cataracts
Mental-Emotional	[] Transient Depression [] Inability to concentrate [] Forgetful [] Worry [] Fear [] Anxiety [] Insecurity [] Loneliness [] Nervousness [] Grief [] Restlessness [] Repetitive thinking [] Spacey	[] Extreme depression with suicidal tendencies [] Anger [] Rage [] Resentful [] Judgmental [] Critical [] Envious [] Sharp tongued [] Vengeful [] Intolerant [] Irritable [] Aggressive [] Success-Failure mind set [] Seeks power, prestige and position	[] Prolonged depression [] Sloppy [] Slow [] Confused [] Greed [] Attachment [] Mental lethargy [] Resistant to change [] Laziness [] Unforgiving [] Stubborn [] Boredom
Nature of response within relationships	[] Talkative [] Uncertain [] Anxious [] Lonely [] Insecure [] Excitable [] Shy [] Spacey	[] Seeks power, prestige and position [] Perfectionist [] Competitive [] Seeker of knowledge	[] Based on acquiring comfort & pleasure