

◆ **CONFIDENTIAL CLIENT HISTORY** ◆

Appointment Date & Time: _____

Name: _____

Address: _____

City, State, Zip: _____

Telephone—Home: _____ Cell: _____ Work: _____

E-mail: _____ Birthdate & Birth Location: _____ Age: _____

Marital/partner status: _____ # of children: _____ Ages: _____

Occupation: _____

How did you hear about Ayurveda/SimpleVeda? _____

Please tell us why you have chosen to have an Ayurvedic Consultation: _____

WHAT YOU CAN EXPECT FROM YOUR AYURVEDIC HEALTH CARE

Ayurveda is a natural healing system that has been successfully practiced for thousands of years. Originating in ancient India, this medical tradition states that each person's path toward optimal health is unique--because each person is unique. The healing programs we offer are based on effective, time-honored principles that focus on understanding your particular body-mind constitution and the unique nature of your imbalance.

Each individualized program is formulated for you by your practitioner. Your program may include lifestyle adjustments, dietary changes, herbs, chakra therapy, yoga, color therapy, sound therapy, aroma therapy, rejuvenation therapies, and other natural therapeutics. In order to successfully implement these Ayurvedic principles into your life, frequent regular follow-up visits with your practitioner are recommended over a six- to twelve-month period.

The goal of all Ayurvedic programs is to create within your body and mind an optimum environment for healing to take place and to maximize your body's ability to heal itself.

Patient (or Guardian) Signature: _____ Date: _____

INFORMED CONSENT AND DISCLAIMER

All Patients who participate in Ayurvedic health care through this program should be advised of the following information:

1. An Ayurvedic Health Practitioner is not trained in Western diagnosis or treatment and will not make suggestions about altering your medical care or medications. In the United States, Ayurveda is a non-licensed profession. Its practice was formally legalized under Senate Bill 577 in January 2003.
2. By changing your lifestyle and living more harmoniously, you will create within your body the optimum environment for healing to take place and a greater sense of well-being that will help you to thrive and not simply survive.
3. If you have specific symptoms that you are concerned about that has not been evaluated by a medical doctor or another licensed healthcare professional, we recommend that you receive a proper evaluation.
4. If you are under medical care or the care of another healthcare provider, your work with your Ayurvedic Health Practitioner will compliment the work being done by your other providers.
5. If you are not under the care of another healthcare provider, the work that you do with your Ayurvedic Health Practitioner will help prevent disease and support your overall well-being.
6. As part of your initial consultation we may take your blood pressure and vital signs, and perform some examination techniques similar to a routine medical examination, we are evaluating our findings from an Ayurvedic perspective only and not from a Western medical perspective. **This examination does not take the place of a medical evaluation. If, as a result of their examination, any findings suggestive of a possible medical imbalance is found, we will refer you to a Medical Doctor for further evaluation.**
7. By signing below, you have read and understand the above information and give your permission to SimpleVeda to begin a program of Ayurvedic health care with a Ayurvedic Health Practitioner.

Patient (or Guardian) Signature: _____ Date: _____

CANCELLATION POLICY:

Our goal is to provide quality care and attention to each client. In order to do so we have implemented a cancellation policy. The policy enables us to better utilize available appointments for our patients in need of care.

We love serving you here at SimpleVeda! We are dedicated to your health journey and put a lot of time, attention and resources into our treatments and consultations. Please understand that we are making a commitment to reserve this time for you and we appreciate you doing the same. Due to the length of appointments, if you cancel your appointment you're inhibiting the ability of others to take this appointment. We ask that if you need to cancel or reschedule that you do so with ample notice. Please call or email by 10:00a.m. two (2) working days prior to your scheduled appointment. If an appointment is cancelled after 10:00a.m. two (2) working days prior to your scheduled appointment you will be charged 50% of the scheduled service. No refunds, returns, or exchanges.

Patient (or Guardian) Signature: _____ Date: _____

CONFIDENTIAL PATIENT HISTORY

(1) PAST MEDICAL HISTORY

Please list any major condition(s) **and** dates of diagnosis, treatment, and procedures performed.

a. Are you under the care of a licensed health care professional or any other healthcare provider? Yes No

If so, for what reasons: _____

b. Serious illnesses: _____

c. Hospitalizations: _____

d. Operations: _____

e. List other pertinent past conditions: _____

f. Have you had any cosmetic surgery or procedures performed? Yes No

If so, please list: _____

(2) FAMILY HISTORY

Indicate what members of your immediate family have had these conditions. (Go back one generation)

(If adopted, answer according to family heritage, if known.)

High Blood Pressure _____ Heart Disease _____ Other _____

Cancer _____ Mental Disorder _____

Stroke _____ Diabetes _____

(3) ALCOHOL, TOBACCO AND SUBSTANCE USE

PRACTITIONER NOTES:

a. Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how often: <input type="checkbox"/> Daily <input type="checkbox"/> Several times weekly <input type="checkbox"/> Several times monthly <input type="checkbox"/> Seldom I usually choose: <input type="checkbox"/> beer <input type="checkbox"/> wine <input type="checkbox"/> sweet or hard liquor	
b. Have you ever smoked tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much per day? _____ If you have quit smoking, when did you quit? _____	
c. Any current or past use of addictive or habitual substances? <input type="checkbox"/> Yes <input type="checkbox"/> No (Note: This will be kept confidential) Please list all substances (either current or long-term past usage): _____ _____ _____	

(4) REGULAR PRACTICES

PATIENT NAME: _____

<input type="checkbox"/> EXERCISE/HATHA YOGA (<i>Specify</i>)	<input type="checkbox"/> None/Never	<input type="checkbox"/> Occasional <input type="checkbox"/> Daily	<input type="checkbox"/> Several times per week <input type="checkbox"/> Several times per month
<input type="checkbox"/> TEAM SPORTS/RECREATION (<i>Specify</i>)	<input type="checkbox"/> None/Never	<input type="checkbox"/> Occasional <input type="checkbox"/> Daily	<input type="checkbox"/> Several times per week <input type="checkbox"/> Several times per month
<input type="checkbox"/> TRAVEL (<i>Include commute if applicable</i>)	<input type="checkbox"/> None/Never	<input type="checkbox"/> Occasional <input type="checkbox"/> Daily	<input type="checkbox"/> Several times per week <input type="checkbox"/> Several times per month
<input type="checkbox"/> SPIRITUAL PRACTICES (<i>Specify</i>)	<input type="checkbox"/> None/Never	<input type="checkbox"/> Occasional <input type="checkbox"/> Daily	<input type="checkbox"/> Several times per week <input type="checkbox"/> Several times per month
<input type="checkbox"/> MEDITATION/PRAYER/PRANAYAMA (<i>Specify</i>)	<input type="checkbox"/> None/Never	<input type="checkbox"/> Occasional <input type="checkbox"/> Daily	<input type="checkbox"/> Several times per week <input type="checkbox"/> Several times per month
<input type="checkbox"/> OTHER (<i>Include creative activities</i>)	<input type="checkbox"/> None/Never	<input type="checkbox"/> Occasional <input type="checkbox"/> Daily	<input type="checkbox"/> Several times per week <input type="checkbox"/> Several times per month

(5) SEXUAL ACTIVITY

According to Ayurveda, a person's level of sexual activity impacts health and well-being in the same way as other aspects of daily life--such as diet or sleep.

a. How often do you engage in sexual activity (include sex with partner and masturbation):

- Daily Several times per week Several times per month Occasionally Not at all

b. Is your current sexual activity satisfactory? Yes No

c. Overall, how would you describe your energy level, morning, afternoon and evening? _____

(6) FOOD CHOICES

What types of foods do you eat on a regular basis?

BREAKFAST: _____

LUNCH: _____

DINNER: _____

SNACKS: _____

(7) DAILY LIQUID INTAKE (*Indicate number of 8 ounce cups per day*)

- Caffeinated Coffee/Tea _____ Herbal Tea or Juice _____ Plain water _____
- Decaffeinated Coffee/Tea _____ Soda or soda pop _____ Cow or Goat Milk _____
- Grain/nut/soy milk _____

(8) HABITUAL EATING PATTERNS

Describe any current or past eating patterns or any other food related issues.

(9) DAILY SCHEDULE (*include approximate times*)

What are your habitual activities from the time you wake up until you go to sleep? Include mealtimes, sleeping, exercise, work, and any activities that occur on a regular basis.

		TIME	HABITUAL ACTIVITIES	NOTES
MORNING	Awaken			
	Mealtime			
	Activities			
DAY	Mealtime			
	Activities			
NIGHT	Mealtime			
	Activities			
	Bed-time			

(10) ALLERGIES OR SENSITIVITIES

Do you have allergic reactions to any substances (including food, pollens, and medicines)? If yes, please list.

(11) AYURVEDIC HISTORY

For each category please identify your tendency over time by placing an "X" in the box that is most appropriate for you.

If you are unsure or would like to speak to your practitioner about this please check (✓) in the column to the right.

Appetite	My hunger level is variable, and I often forget to eat. <input type="checkbox"/>	I have a strong appetite and don't like to miss meals. <input type="checkbox"/>	I like to eat, but I can go without eating with no discomfort. <input type="checkbox"/>
	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
Appetite	If I miss a meal, I often get light-headed, anxious or cranky. <input type="checkbox"/>	If I miss a meal, I often get irritable or angry. <input type="checkbox"/>	If I miss a meal, it doesn't really bother me. <input type="checkbox"/>
	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
Appetite	I prefer to eat frequently with no set schedule, but I often forget to eat. <input type="checkbox"/>	I prefer to eat 3 meals a day at about the same time. I rarely skip meals. <input type="checkbox"/>	I prefer to eat 2 to 3 times daily, but can go without eating. <input type="checkbox"/>
	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
Digestion	After eating, I often experience gas or bloating <input type="checkbox"/>	After eating, I often experience heartburn or acidity. <input type="checkbox"/>	After eating, I often feel heavy or sleepy. <input type="checkbox"/>
	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
Elimination	I tend to have irregular bowel movements one time per day or less. <input type="checkbox"/>	I tend to have 1 to 2 bowel movements daily, usually with regularity and ease. <input type="checkbox"/>	I tend to have one bowel movement per day with no straining or difficulty. <input type="checkbox"/>
	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	<i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>

Elimination	My bowel movements are often dry and hard. At times I may strain or push. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	My bowel movements are usually well-formed, but sometimes they are loose and may burn. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	My bowel movements are usually well-formed, slow and easy. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
Weight	I usually don't gain weight very easily. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	When I gain weight, it is easy to lose it. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	I gain weight easily and lose it slowly. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
Body Temperature	My hands and feet often feel cold, and I prefer warmer climates. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	I am warm most of the time no matter what the climate is. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	I adapt easily to most conditions, but tend to feel cool. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
Skin	My skin tends to be dry. When very dry it tends to feel rough. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	My skin flushes easily and has a reddish or yellowish shade. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	My skin is thick, smooth and often feels damp or oily. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>

Skin	When I have rashes, they tend to be dry and itchy. Blemishes are usually blackheads. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	When I have rashes, they tend to be red and burning. Blemishes are usually acne. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	When I have rashes, they tend to be wet and oozing. Blemishes are usually white pimples. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
Sleep	I tend to sleep lightly and awaken very easily. It can be difficult for me to go to sleep. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	I tend to sleep soundly and awaken with ease. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	My sleep tends to be deep and long. It can be difficult for me to awaken in the morning. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>

MENTAL & EMOTIONAL PATTERNS

Stress	Under stress I often become worried or overwhelmed. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	Under stress I often become irritable, but usually rise to the challenge. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	Under stress, I often withdraw to observe or become reclusive. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
Decision Making	I am changeable and often have difficulty making decisions. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	I make decisions easily, but can change my mind with new information. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	I am careful but easy-going about decisions. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
Projects	I like to start projects, but at times have difficulty finishing them. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	I like to start and finish projects. Completion is important to me. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	I like working on a project, but prefer to let others start them. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>

FOR WOMEN ONLY

Is there a possibility you are pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Possible Are you menopausal? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of last period _____ If menopausal, please answer below according to your past menstrual patterns. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>		I experience PMS: <input type="checkbox"/> often <input type="checkbox"/> sometimes <input type="checkbox"/> not at all <input type="checkbox"/> cramps <input type="checkbox"/> bloating <input type="checkbox"/> headache <input type="checkbox"/> weight gain <input type="checkbox"/> irritable <input type="checkbox"/> breast tenderness <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
My menstrual cycle is irregular. It comes every ___ to ___ days and lasts ___ days. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	My menstrual cycle is regular. It comes every ___ days, and lasts ___ days. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	
My menstrual flow is often light, but may vary. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	My menstrual flow is medium heavy, and is usually consistent. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	My menstrual flow is heavy and is very consistent. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>
I often have severe, cramping pain during menses. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	At times, I have mild pain during menses. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>	I rarely have pain during menses. <i>Practitioner use only</i> V <input type="checkbox"/> P <input type="checkbox"/>

PATIENT NAME: _____

MENTAL AND EMOTIONAL PATTERNS

<i>When I am having a bad day, I am challenged by:</i>			<i>When I am having a good day and feeling at ease, I would describe myself as:</i>	
Emotion	Scale of 1 to 10 (1 is the mildest and 10 is the strongest)	Frequency: Number of times per week, month of year	Personality	Scale of 1 to 10 1 seldom and 10 most often
Worry			Creative	
Anxiety			Enthusiastic	
Overwhelm			Vivacious	
Self-destructiveness			Thoughtful	
Anger			Philosophical	
Resentment			Perceptive	
Jealousy			Disciplined	
Intensity			Logical	
Rage/Violence			Nurturing	
Melancholy			Calm and stable	
Depression			Unconditionally loving	
Stubborn				
Controlling				
Apathetic				
Sentimental				

PLEASE DESCRIBE YOUR CURRENT EMOTIONAL STATE:

PRACTITIONER USE ONLY:

VIKRUTI

PRAKRUTI

V	P	K
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V	P	K
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(12) CURRENT MEDICATIONS, HERBS OR SUPPLEMENTS

What medications, herbs, supplements are you currently taking?

Please include significant remedies that you have *stopped* taking, including birth control and hormone replacement therapies.

<i>Substance</i>	<i>Over-the-counter (OTC) Prescription? (Rx)</i>	<i>Herb/ Drug/ Vitamin?</i>	<i>Prescribed by? (Self, MD, other)</i>	<i>For what purpose?</i>	<i>For how long?</i>	<i>What dosage?</i>	<i>What have the benefits been?</i>