Ambika's Ayurveda

www.ayurvedarejuvenation.com

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530-518-3368

Name_____

Address_____

City, State, Zip_____

Phone (cell/home)_____

Email_____

Birthdate and birthtime_____

Birthplace (City, State, Country)_____

Marital Status_____**No. of children**_____

Is there any possibility you are pregnant?_____**Are you breastfeeding?**_____

Family Physician_____

OBJECTIVES

Please check the items that reflect your main objectives

- I want an alternative approach to allopathic medicine for managing illness and disease
- I want to improve my general health and wellness and reduce my vulnerability to illness and disease
- I want to improve my lifestyle and dietary practices to improve my health
- I want to change my habits and behavioral patterns to improve my relationship to others
- I want to manage stress, tension and worry to attain a more stable emotional nature

REVIEW OF CONCERNS

List your chief complaint and any other significant symptoms you are concerned about. If you have been diagnosed with a disease or condition and are taking medication for them, list that here as well.

Health Concerns_____

Diagnosed Conditions and medications _____

_____

_____

Please check the digestive, elimination, and emotional challenges that you experience. Indicate current conditions with a (C) and occasional conditions with (O)in each category.

Digestion

__Abdominal Pain **__Burning Indigestion** **__Nausea/Vomiting**

__Excessive Gas **__Heartburn** **__Sluggish After Eating**

__Belching **__Smelly Gas** **__Bloating**

__Other_____

Elimination

__Constipation **__Regular/Soft Stool** **__Regular/Oily/Mucus in Stool** **__Diarrhea**

Psychology

__Worry/Anxiety **__Irritable/Anger** **__Lethargy/Slow Pace**

__Fear **__Rage** **__Depression**

__Fog **__Jealousy/Envy** **__Over Attachment**

__Insomnia/light sleep **__Moderate Sleep (6-8 hours)** **__Heavy Sleep (8-10hours)**

__Indecisive/Impulsive **__Decisive and focused** **__Slow in decision making but steady**

__Changeable **__Flying/fearful dreams** **__Violent/Fiery Dreams**

__Romantic, water dreams/swimming

Comments:

General Health and Lifestyle Patterns

1. **Do you exercise regularly? ____Y___N. Times per week_____ Length of Time_____**
2. **How much of the following do you drink? (Note: 1 cup = 8 ounces)**

   Non-caffeinated beverages: herbal tea, milk, juice, etc_____cups

   Caffeinated beverages: coffee, tea, soda_____cups

   Water: _____cups

Alcohol: Cups per day_____week_____month____

3. **Do you currently smoke? (tobacco or marijuana) _____**

   How often? _____ How long have you smoked? _____

   Have you smoked in the past? If so, for how long and how often?

   _____

4. **Any current or past use of addictive substances? ___Yes___No___Quit?_____When?**

If yes, please _____

5. **Do you experience allergic reactions to any substances? (food, drugs, environment, etc.) Please share**

_____

6. **What type of work do you do?_____**
7. **Please rate your work level of stress (1= least, 5=most)_____Rate your satisfaction_____**
8. **Are you currently experience stress in any close relationships? If yes, please share**

_____

9. **Are you sexually actice?___yes____no. Rate your libido (1=least, 5=most)___Rate your satisfaction_____**
10. **Do you have any specific spiritual practices? Please describe**

    _____

    _____

11. **Height_____ Weight_____ How long have you been at this weight?_____**

Dietary Patterns

What kinds of taste do you prefer? Please mark one of the following.

___Sweet____Sour_____Salty_____Pungent___Bitter___Astringent

Any current or past chronic eating disorders or other food related issues?_____yes_____no

Please share your primary food choices and meal times below

Meal Times/Typical Foods/Beverages

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Current medications, herbs, or supplements

Please share about medications and supplements you are taking or have taken recently, including birth control

_____

_____

_____

_____

For Women Only

Menstrual History

Describe your period (heavy/ light, consistent/inconsistent, cycle length, PMS symptoms)

_____

_____

_____

Are you currently in menopause? Do you have any pre/post menopause symptoms? Please share

_____

_____

_____

Medical History

Personal and family medical history. Check all that apply on the next page

Allergies to food or drugs ___yes ___no

Anemia _____yes _____no

Arthritis ____yes -_____no

Asthma, Pneumonia, TB _____yes ____no

Blood Pressure, high/low _____

Cancer_____yes ____no_____type

Chronic Constipation ____yes_____no

Chemotherapy/Radiation_____yes_____no

Chest Pain _____yes _____no

Elevated Cholesterol ____yes _____no

Dental Complications _____yes ___no

Diabetes _____yes _____no

Dizziness ____yes _____no

Epilepsy, convulsions, seizures _____yes _____no

Fainting ____yes _____no

Feet or ankle swelling ____yes ____no

Glaucoma, eye surgery ____yes ____no

Heart Attack ____yes____no

Heart Disease/Heart Murmur ____yes _____no

Implant/Prosthesis___yes___no (type)_____

Heart Surgery_____yes_____no

Hepatitis A, B, or C ____yes _____no (type)____

HIV diagnosis/exposure ___yes___no

Frequent colds or coughs____yes _____no

Chronic Diarrhea ____yes ____no

Kidney or Bladder disease ____yes ____no

Mental Disorder ____yes ___no(type)_____

Jaundice/Gallstone _____yes _____no

Ear Pain or ringing ____yes _____no

Jaw pops, clicks or locks ____yes ____no

Prolonged Bleeding when cut ___yes ___no

Rheumatic Fever ___yes ____no

Sinusitis _____yes _____no

Shortness of Breath _____yes _____no

Stroke _____yes _____no

Thyroid Disease _____yes _____no

Ulcers, intestinal Bleeding ____yes _____no

Venereal Disease ____yes _____no

Please share an additional comments or conditions not listed above:

_____

_____

_____

Are you or have you recently been under the care of a licensed physical physician? Date of last exam?_____

Any past history of?

__serious injuries __trauma __emotional/mental stressed

__troubled lifestyle conditions __ changes in weight? __aches, pains

__stress __fatigue __mental clarity/concentration __hot flashes

__vision problems, including dry eyes ___cosmetic surgery

Please describe any items checked or share additional comments

_____

_____

_____

_____

_____

How did you hear about us? (website, friend, social media, etc)_____

How will you be paying today? (credit card, cash, check?)_____