Ayurvedic Health Counseling Intake Form

Date: _____ Name_____ D.O.B._____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Partnership

Age_____ Height: _____ Weight: Past: _____ Current: _____ Occupation: _____

Address: _____ State: _____ Zip: _____

Phone: _____ e-mail: _____

Emergency Contact: _____ Relation: _____

Emergency Contact Phone: _____

Please describe your present health concerns and their duration. What motivated you to embark on an Ayurvedic approach?

_____

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Are you currently under the care of family physician or any other health professional?
☐ Yes ☐ No If yes, please explain

Are you currently taking any medications and/or receiving any medical treatment for your health condition?
If so, please list all medications/treatments and their dosage:

Are you allergic to any substances? Please specify: food, pollen, dust etc., and any other allergic reactions?

Do you have any past medical history? If yes, please specify the age of occurrence, duration and its treatment.

Health as a child: ☐ Good ☐ Fair ☐ Poor

How would you rate your usual energy level?
☐ Very high ☐ High ☐ Moderate ☐ Low ☐ Very low

Digestion

Do you experience any of the following?

☐ Gas	☐ Heartburn	☐ Low appetite
☐ Bloating	☐ Sour burps	☐ Nausea
☐ Constipation	☐ Diarrhea	☐ Heavy feeling in stomach

Bowel Movements

☐ Once every 2-3 days	☐ Once daily	☐ 2-3 times per day
☐ First thing in the morning	☐ Late in daytime	☐ Immediately after meals
☐ Immediately after dinner	☐ Need laxative daily	☐ Other, please specify_____

Bowel nature: ☐ Soft ☐ Medium ☐ Hard

Bowel movement associated with: ☐ Pain ☐ Gas ☐ Blood ☐ Mucous ☐ Foul smell ☐ Other _____

Urination

Do you have any of the following urinary problems?
☐ Pain ☐ Burning sensation ☐ Discoloration ☐ Frequent urination during the day
☐ Urination several times during the night ☐ Other _____

Natural Urges

Do you delay or suppress any of the following?

☐ Bowel movements	☐ Gas	☐ Urination	☐ Sleep	☐ Yawning	☐ Burping
☐ Breathing	☐ Sneezing	☐ Hunger	☐ Thirst	☐ Semen	☐ Cry, tears

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Sleeping

What time to you wake up? _____ What time do you go to bed? _____ Do you sleep in the daytime? ☐ Yes ☐ No

How do you generally feel on arising in the morning?
☐ Fresh and rested ☐ Little tired ☐ Very tired

How is your sleep?
☐ Sound, normal duration ☐ Light, interrupted ☐ Too little sleep
☐ Too heavy and or too long ☐ Difficulty falling asleep ☐ Difficulty waking up
☐ Awaken too early ☐ Frequent nightmares

Emotions

What is your present state of mind and emotions? ☐ Good ☐ Fair ☐ Poor

Do you often experience any of the following?
☐ Worry ☐ Anxiety ☐ Fear or panic ☐ Loneliness
☐ Depression ☐ High stress level ☐ Lack of memory ☐ Light-headedness
☐ Lack of energy ☐ Anger ☐ Irritation

How are your family relationships? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How is your social life? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How is your mental status? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How is your career? ☐ Love it ☐ Like it ☐ Dislike it

How purposeful is your life? ☐ Completely ☐ Neutral ☐ Not happy

Rate your spiritual life: ☐ Satisfying ☐ Neutral ☐ Empty

What types of activities do you engage in to take care of your well-being? How do you spend your leisure time?

Have you ever been hospitalized for a psychiatric condition? ☐ Yes ☐ No *If yes, please explain.*

Are you currently being treated for an addiction? ☐ Yes ☐ No

Describe what it looks like when you feel despair. How does it manifest for you?

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Daily Routine

How regular is your daily routine (for example, do you go to bed early, eat your meals on time, exercise regularly etc.?)
☐ Very regular ☐ Somewhat regular ☐ Irregular

Do you practice any type of meditation? Please explain.

Do you practice any Yoga techniques? Please explain.

Do you travel a lot? ☐ Yes ☐ No
If yes, how frequently? Circle one: More than once a day / several times a week / several times a month / several times a year

How often do you smoke cigarettes? Circle one.
Never / less than once a week / about once a week / several times a week / more than once a day
How much: _____

How often do you smoke marijuana? Circle one.
Never / less than once a week / about once a week / several times a week / more than once a day
How much: _____

How often do you drink alcohol?
Never / less than once a week / about once a week / several times a week / more than once a day
How much: _____

How often do you drink caffeinated (coffee, tea etc.) beverages? Never / one cup daily / 2 – 3 cups daily / 4 – 5 cups daily

Which type of weather makes you feel most uncomfortable? (Choose one) ☐ Cold ☐ Hot ☐ Cool and damp

Physical Body

What is your body build? ☐ Thin ☐ Large ☐ Average ☐ Muscular

Are you overweight? ☐ Yes ☐ No If so, by how much?
☐ Less than 15 pounds ☐ 15-30 pounds ☐ 30-50 pounds ☐ More about 50 pounds

How often do you exercise?
☐ Weekly once ☐ Weekly twice ☐ 3-4 days weekly ☐ 5-6 days weekly ☐ Every day ☐ Not at all

How long do you exercise? _____ What type of exercise? _____

Is your exercise: (choose one) ☐ Vigorous ☐ Moderate ☐ Light

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Food Practices

Food groups	Daily	Weekly	Monthly	Never
Grains / Cereals				
Vegetables				
Fruits				
Dairy				
Eggs				
Poultry				
Meat				
Seafood				
Sugar / Honey				
Desserts				
Juices				
Other				

Please explain what you typically eat for meals?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you eat between meals? ☐ Yes ☐ No

Do you eat your meals at the same times daily? ☐ Yes ☐ No

Which is your main meal? ☐ Breakfast ☐ Lunch ☐ Dinner

Rate your digestion: ☐ Good ☐ Fair ☐ Poor

How much water you drink per day? Never / 1-2 glasses / 3-4 glasses / 5-6 glasses / 7 glasses and more

My eating habits include:
☐ Eat with full attention on food ☐ Talk or converse a lot while eating ☐ Eat very fast
☐ Watch television while eating ☐ Never sit to eat

Describe your diet: ☐ Vegan ☐ Lacto-vegetarian ☐ Ova-lacto-vegetarian ☐ Others please specify .....

Non-vegetarian:
☐ Beef ☐ Pork ☐ Chicken ☐ Turkey ☐ Seafood ☐ Eggs ☐ Others please specify .....

What taste(s) do you like or crave? ☐ Sweet ☐ Salty ☐ Bitter ☐ Sour ☐ Hot/Spicy ☐ Starches ☐ Oily

Are there any particular foods that create discomfort when you eat them?
☐ Sweet ☐ Sour ☐ Oily or fatty ☐ Hot ☐ Salty ☐ Bitter ☐ Astringent ☐ Dairy products (including cheese)
☐ Other _____

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For Women:

Age menses began: _____

Which of the following describes your menstruation? (You may choose more than one)
☐ Regular ☐ Irregular ☐ Too frequent ☐ Absent ☐ Ceased due to menopause

How many days does your menstrual period last?
☐ Zero to four days ☐ Five to seven days ☐ More than seven days ☐ Spotty irregularly throughout the month
☐ Other, please explain _____

How is your menstrual flow? ☐ Heavy ☐ Light ☐ Normal
Associated symptoms (before or during menstruation):
☐ Food Cravings ☐ Cramping ☐ Fluid retention ☐ Migraine ☐ Depression
☐ Acne ☐ Tension ☐ Anger ☐ Frustration ☐ Breast tenderness
☐ Nightmares ☐ other, please specify _____

How would you describe your libido? ☐ Strong ☐ Moderate ☐ Low

Do you experience pain during intercourse? ☐ Yes ☐ No

Do you have any sexual difficulties? ☐ Yes ☐ No
If yes, please explain _____

Are you pregnant now? ☐ Yes ☐ No ☐ Don't know

Do you take contraceptive pills or other devices? ☐ Yes ☐ No If yes, Please explain _____

Number of previous pregnancies (choose one) _____

How many children do you have? _____ Children's ages: _____

Do you self-exam breasts regularly? _____

Do you experience any problems in breasts? ☐ Lumps ☐ Pain or tenderness ☐ Nipple discharges ☐ Other _____

For Men:

How would you describe your libido? ☐ Strong ☐ Moderate ☐ Low Erections: ☐ Sustained ☐ Lost

How many children do you have? _____ Children's ages: _____

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When answering the following questions, evaluate your *current* state of being. Circle one description for each row, or two if there are the answers are close.

Mental Profile

	Category I		Category II		Category III	
Mental activity	Quick, active, restless		Sharp, critical, aggressive		Calm, steady, slow, stable	
Memory	Short term		Generally good		Good long term	
Concentration	Weak		Generally good		Very good	
Ability to learn	Quick to grasp concepts		Moderate ability to grasp new information		Slow to grasp new information	
Dreams	Fearful, very active, flying,		Aggressive, fiery, adventurous		Watery, romance, relationships	
Sleep	Light, interrupted		Sound, medium		Sound, heavy, long	
Speech	Quick, can miss words		Sharp, direct, strong		Slower, clear, melodious	
Voice	High pitched		Medium pitched		Low pitched	
Sub-total						

Behavioral Profile

	Category I		Category II		Category III	
Eating Speed	Fast		Medium		Slow	
Hunger level	Irregular		Sharp, can be strong		Can easily miss meals	
Food/Drink	Prefers warm		Prefers cold		Prefers dry and warm	
Achieving goals	Easily distracted		Focused and driven		Slow and steady	
Giving/donations	Gives small amounts		Gives nothing or large amounts infrequently		Gives regularly and generously	
Relationships	Many casual		Intense		Long and deep	
Sex drive	Variable, low		Moderate		Strong	
Works best	Supervised		Alone		In groups	
Weather preference	Warm and moist		Cool and dry		Warm and dry	
Reaction to stress	Excites quickly		Medium		Slow to get excited	
Financial	Doesn't save, spends quickly		Saves but big spender		Saves regularly, accumulates wealth	
Routine	Dislikes routine		Likes planning and organizing		Works well with routine	
Sub-total						

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Emotional Profile

	Category I		Category II		Category III	
Moods	Changes quickly		Changes slowly		Steady, unchanging	
Reacts to stress with	Fear		Anger		Indifference	
More sensitive to	Own feelings		Not sensitive		Others feelings	
When threatened tends to	Run		Fight		Make peace	
Relations with spouse/partner	Clingy		Jealous		Secure	
Expresses affections	With words		With gifts		With touch	
When feeling hurt	Cries		Argues		Withdraws	
Emotional trauma causes	Anxiety		Denial		Depression	
Confidence level	Timid		Outwardly self-confident		Inner confidence	
Sub-total						

Physical Profile

	Category I		Category II		Category III	
Amount of hair	Average		Thinning		Thick	
Hair type	Dry, frizzy, thin, dark		Straight, fine, premature graying		Oily, wavy, thick	
Hair color	Light brown, blond		Auburn, reddish		Dark brown, black	
Skin	Dry, rough or both, dark/sallow, tans easily, cold		Soft, normal to oily, light, sunburns easily, warm		Oily, moist, fair, thick, cool	
Complexion	Darker		Pink, red		Pale-White	
Eyes	Small, brown, gray, violet, unusual color		Medium, Green, hazel, almond-shaped		Large, dark, blue	
Whites of eyes	Blue/brown		Yellow or red		Glossy/white	
Teeth	Very large or very small		Small -medium		Medium-large	
Weight	Thin, hard to gain		Medium		Heavy, easy to gain	
Elimination	Dry, hard, thin, easily constipated		Many during day, soft to normal		Heavy, slow, thick, regular	
Sweat	Scanty		Profuse		Moderate	
Sub-total						

TOTALS						