MEDICAL AYURVEDA REJUVENATION CENTER

CONFIDENTIAL CLIENT HISTORY

Client's Name: _____

Client's Address: _____

City, State, Zip: _____

Telephone—Home: _____ Work: _____email:_____

Social Security #: _____Birth date: _____Age: _____

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

Occupation: _____

How did you hear about the Medical Ayurveda Rejuvenation Center? : _____

FINANCIAL POLICY AGREEMENT

1. There is a $_____ charge for each consultation with a Clinical Ayurvedic Specialist. This includes the initial interview and report of findings meeting.

2. There is a charge for custom-made Herbal Formulas, made at the *Medical Ayurveda Rejuvenation Center*. Price depends upon the Herbs used.

3. Fees for herbs must be paid in advance at the time they are ordered. Payment may be made by check or major credit card. The Center does not provide monthly billing.

4. The Center does not bill insurance companies for services or herbs. However, a bill for insurance companies may be provided upon patient's request.

5. Pancha Karma services may be recommended and provided at the Center. Payment for those services is due to the Center when the appointments are scheduled.

6. If you miss an appointment with your clinician without giving 24 hours notice, a 50% of the fee is charged to your account for first time cancellation and 100% of the fee for second time cancellation.

I have read and understood the financial policies of the Medical Ayurveda Rejuvenation Center.

Client's Signature: _____ Date: _____

INFORMED CONSENT

to receive Alternative Health Care through the

MEDICAL AYURVEDA REJUVENATION CENTER

All clients who participate in Ayurvedic health care should be advised of the following:

1. The goal of all 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 using the principles of Ayurveda.

2. The Medical Ayurveda Rejuvenation Center is not a primary care medical clinic.

3. Not all our clinicians are trained in Western medical diagnosis or treatments.

6. If you are suffering from a disease or symptom that has not been evaluated by a medical doctor or another licensed health care professional, you must be evaluated by a medical doctor. If you choose not to see a medical doctor, you will have to sign an acknowledgment that one was recommended to you.

7. Clinicians working for the Medical Ayurveda Rejuvenation Center may not alter your prescriptions without approval from your medical doctor.

8. I give permission for the Medical Ayurveda Rejuvenation Center to use the information in my chart for research purposes. (Any publication of our research will not include patient names.)

9. The medical Ayurveda Rejuvenation Center waives all liability for any side-effects or complications resulting from the use of its herbal supplements and treatments. Please inform your Ayurvedic consultant before taking Ayurvedic herbs inconjunction with allopathic medication or other herbal supplements.

I have read and understand the above information.

Client's Signature: _____Date: _____

CHIEF HEALTH CONCERNS

What are your main health concerns at this time? Order by importance to client.

PRIMARY CONCERNS	CLINICIAN NOTES
1.	
2.	
3.	
4.	
5.	
6.	

PAST MEDICAL HISTORY

Include major conditions, dates of treatment and procedures performed.

1. Serious illnesses:_____

_____

2. Hospitalizations: _____

3. Operations: _____

4. List other pertinent past conditions: _____

_____

5. Have you been under the care of a licensed health care professional in the past year? ❑**Yes** ❑**No**

If so, for what reasons: _____

6. Is there any possibility that you are pregnant? ❑ Y ❑ N

FAMILY HISTORY ***PLEASE CHECK THE APPROPRIATE BOXES AND INDICATE FAMILY MEMBER.***

❑ Cancer	❑ Diabetes
❑ High Blood Pressure	❑ Heart Disease
❑ Stroke	❑ Mental Disorder
❑ Other (explain)	❑ Other (explain)

CURRENT MEDICATIONS, HERBS OR SUPPLEMENTS

What medications, herbs, supplements are you currently taking?
Please include significant remedies that you have recently stopped taking.

Name of substance: ______________________________

❑ *Prescription* ❑ *over-the-counter* ❑ *herbal* ❑ *vitamin* ❑ *other*

Who recommended/prescribed it?______________________________

Purpose of substance: ______________________________

How long have you been taking it:______________________________

In what form do you take it (include dosage): ______________________________

How often do you take it? ______________________________

What effects have you noticed? ______________________________

Name of substance: ______________________________

❑ *Prescription* ❑ *over-the-counter* ❑ *herbal* ❑ *vitamin* ❑ *other*

Who recommended/prescribed it?______________________________

Purpose of substance:______________________________

How long have you been taking it:______________________________

In what form do you take it (include dosage): ______________________________

How often do you take it? ______________________________

What effects have you noticed?______________________________

Name of substance:______________________________

❑ *Prescription* ❑ *over-the-counter* ❑ *herbal* ❑ *vitamin* ❑ *other*

Who recommended/prescribed it? ______________________________

Purpose of substance: ______________________________

How long have you been taking it: ______________________________

In what form do you take it (include dosage):______________________________

How often do you take it? ______________________________

What effects have you noticed?______________________________

DAILY ROUTINES

To be filled out by client

DAILY SCHEDULE *(include approximate times)*

1. Describe your activities from the time you wake up until you go to sleep. (Eating, sleeping, exercise, work, activities).

	Time	*Activities*	
Morning			*VARIATIONS*
Awaken			
Breakfast			
Activities			
Mid-day			
Lunch			
Activities			
Evening			
Supper			
Activities			
Night			
Activities			
Bed-time			

2. List regular practices that are not included in the above schedule, e.g., exercise, meditation, spiritual practices, etc.

_____

_____

3. Are you sexually active? Y q *N* q *Frequency?*

4. Other comments about daily routines:

_____

CHILDHOOD HISTORY:

5. What types of food(s) are eaten on a regular basis?
*BREAKFAST:*_____
_____

*LUNCH:*_____
_____

*DINNER:*_____
_____

*SNACKS:*_____

6. Are there any routines around eating:

7. Any current or past problems with chronic eating disorders or other food related issues? q ***Y*** q ***N***

ALLERGIES OR SENSITIVITIES

8. Do you have allergic reactions to any substances? If yes, please list.

_____

_____

GENERAL HEALTH HABITS

9. How many cups of caffeinated beverages do you drink per day?
 # _____ Type(s) of beverage: coffee/tea/soda
10. How many cups of non-caffeinated beverages do you drink per day?
 # _____ Type(s) of beverage: herbal tea/milk/juice/other
11. How much water do you drink per day?
_____
12. Do you exercise regularly? q *Y* q *N*
Length of time: _____ Times per week:
_____
Type(s) of exercise:
_____
13. If you smoke, how many cigarettes do you smoke per day? _____
Have you ever smoked? q *Y* q *N Amount/day: _____ When quit? _____*
14. If you drink alcohol, how many glasses of alcohol per week? (Include beer, wine, liqueurs and hard liquor)
 # _____per week Type(s) of beverage: _____
15. Any current or past problems with addiction or substance abuse? q *Y* q *N*
Substance: _____ Amount: _____ When quit? _____

Manas-emotions overview

When I'm feeling at ease and content, I would describe myself as:

	1=not much 5=a lot	How often do you experience this? >3x/wk	1x/wk	1x/mo	1x/yr		1=not much 5=a lot	How often do you experience this? >3x/wk	1x/wk	1x/mo	1x/yr
Enthusiastic	1 2 3 4 5	❑	❑	❑	❑	Logical	1 2 3 4 5	❑	❑	❑	❑
Creative	1 2 3 4 5	❑	❑	❑	❑	Nurturing	1 2 3 4 5	❑	❑	❑	❑
Courageous	1 2 3 4 5	❑	❑	❑	❑	Patient	1 2 3 4 5	❑	❑	❑	❑
Perceptive	1 2 3 4 5	❑	❑	❑	❑	Forgiving	1 2 3 4 5	❑	❑	❑	❑
Disciplined	1 2 3 4 5	❑	❑	❑	❑	Calm/stable	1 2 3 4 5	❑	❑	❑	❑

Predominant Mental/Emotional State: **V P K**

When I'm having a bad day, I'm challenged by:

	1=not much 5=a lot *(circle)*	How often does it challenge you? >3x/wk	1x/wk	1x/mo	1x/yr	For Office Use Only
Worry	1 2 3 4 5	❑	❑	❑	❑	
Anxiety/Fear	1 2 3 4 5	❑	❑	❑	❑	
Overwhelm	1 2 3 4 5	❑	❑	❑	❑	
"Spaceyness"	1 2 3 4 5	❑	❑	❑	❑	
Self Destructiveness	1 2 3 4 5	❑	❑	❑	❑	
Anger/Rage	1 2 3 4 5	❑	❑	❑	❑	
Resentment	1 2 3 4 5	❑	❑	❑	❑	
Jealousy/Envy	1 2 3 4 5	❑	❑	❑	❑	
Being critical	1 2 3 4 5	❑	❑	❑	❑	
Lethargy	1 2 3 4 5	❑	❑	❑	❑	
Sadness	1 2 3 4 5	❑	❑	❑	❑	
Depression	1 2 3 4 5	❑	❑	❑	❑	
Greediness	1 2 3 4 5	❑	❑	❑	❑	

Predominant Negative Emotions (assess those valued from 3 to 5) Doshic Imbalance: (explain) **V P K**

REVIEW OF SYMPTOMS

Check all symptoms that are of concern to you at this time that you want to discuss with the practitioner.

Concern	Office	HEAD
		Headaches
		Dizziness
		Fainting spells
		Loss of balance
		Difficulty remembering
		Difficulty thinking clearly
		Thinning or loss of hair

Concern	Office	EARS
		Hearing loss
		Ringing
		Earaches–Pain
		Discharges
		Bleeding

Concern	Office	EYES
		Pain–soreness in eyes
		Redness
		Burning
		Mucous
		Dryness
		Itching
		Tic/twitch
		Blurred/loss of vision

Concern	Office	NOSE
		Loss of smell
		Bleeding
		Pain
		Discharge
		Post-nasal drip

Concern	Office	MOUTH
		Excessive thirst
		Loss of taste
		Strange taste
		Bad breath
		Lip ulcers or lesions
		Dry/cracking lips
		Tongue pain
		Bleeding gums
		Receding gums
		Tooth pain
		TMJ

Concern	Office	NECK
		Pain
		Swollen glands
		Lumps
		Stiffness

Concern	Office	CHEST
		Pain in chest
		Tightness/pressure in chest
		Heart palpitations
		Shortness of breath
		Painful–difficult breathing
		Persistent cough
		Frequent chest colds

Concern	Office	SKIN
		Dry–flakey
		Rashes
		Blisters
		Acne
		Changing or bleeding

		Sinus Congestion

Concern	Office	DIGESTION
		Pain
		Burning indigestion
		Belching
		Regurgitation
		Vomiting
		Excessive Gas
		Heavy–Bloaty after eating
		Hemorrhoids
		Constipation (< 1 BM/day)
		Diarrhea
		Both constipation & diarrhea
		Bloody Stool

Concern	Office	URINARY
		Loss of urination control
		Painful urination
		Urine retention, dribbling
		Daytime urination often
		Nighttime urination often
		Blood in urine
		Pain in kidney/groin area
		Kidney/bladder infections

Concern	Office	MUSCLES&JOINTS
		Swelling in joints
		Pain/ache in joints
		Stiff joints

		moles
		Response to insect bites

Concern	Office	CIRCULATION
		Varicose veins
		Cold hands–feet
		Swollen ankles
		Calf pain
		Puffy eyes

Concern	Office	FEMALE SYSTEM
		Irregular cycle
		Heavy/prolonged bleeding
		Missed menses
		Painful menses
		Spotting
		Discharge
		PMS symptoms
		Pregnant
		Miscarriage
		Infertility
		Genital sores
		Ovarian cyst
		Fibroids

Concern	Office	BREASTS
		Swelling
		Redness
		Lumps
		Nipple discharge
		Tenderness–pain

		Persistent muscle/bone pains
		Tremors/tics in muscles
		Muscle weakness/atrophy

Concern	Office	NERVES
		Loss of taste, smell or touch
		Tingling sensations
		Tremors in limbs
		Uncoordinated muscle/limbs

Concern	Office	MALE SYSTEM
		Prostate gland swollen/painful
		Low sperm count
		Low motility
		Genital sores or lesions
		Genital discharge
		Erection difficulty

1. Describe your appetite.

	SHORT-TERM	LONG-TERM	
Hunger level	*Variable, strong, low*	*Variable, strong, low*	Short-term V P K
Typical quantity and frequency	*Small meals, medium meals, large meals Regularly, irregularly, 1 2 3 4+ times/day*	*Small meals, medium meals, large meals Regularly, irregularly, 1 2 3 4+ times/day*	
Reaction to missing meals	*anxious, light-headed, irritable, not significant*	*anxious, light-headed, irritable, not significant*	Long-term V P K

2. Describe your digestion after eating.

	SHORT-TERM	LONG-TERM	
After eating response.	*Gas, pain, bloat, heartburn, indigestion, heavy, sluggish, sleepiness*	*Gas, pain, bloat, heartburn, indigestion, heavy, sluggish, sleepiness*	Short-term V P K Long-term V P K
Timing of response	*2+ hours after eating, 1 hour after eating, immediately after eating, other (describe)*	*2+ hours after eating, 1 hour after eating, immediately after eating, , other (describe)*	
Trigger foods (cause problems)			

3. Describe your elimination patterns, specifically bowel movement patterns.

	SHORT-TERM	LONG-TERM	
Frequency: times per day	*Less than 1x per day, 2x per day or more, 1x per day regular, irregular*	*Less than 1x per day, 2x per day or more, 1x per day regular, irregular*	Short-term V P K
Consistency	*Dry, pellets, loose, unformed, formed, mucousy, soft*	*Dry, pellets, loose, unformed, formed, mucousy, soft*	
Level of comfort	*Straining, burning, slow, easy, no problem*	*Straining, burning, slow, easy, no problem*	Long-term V P K
Stool Density	*Float, sink, scatter*	*Float, sink, scatter*	

4. Describe your weight pattern over time.

Weight patterns	*Thin, yo-yo, easy to lose, variable*		*V P K*
	Moderate, steady, slow gain with age		
	stocky, heavy, hard to lose		

5. Do you tend to feel warm or cold more often?

	SHORT-TERM	LONG-TERM	
Body temp	*Cool, variable, warm*	*Cool, variable, warm*	Short-term V P K
Climate preferred	*Tropical, cool/rainy, desert, moist, dry*	*Tropical, cool/rainy, desert, moist, dry*	Long-term V P K

6. Describe your sweating pattern.

	SHORT-TERM	LONG-TERM	
How much do you sweat?	*Hardly at all, medium, profuse*	*Hardly at all, medium, profuse*	Short-term V P K
Exertion/heat needed to sweat	*Lots, moderate, hardly any*	*Lots, moderate, hardly any*	
Odor of sweat	*Hardly any, quite potent, some*	*Hardly any, quite potent, some*	Long-term V P K

7. Describe the qualities and condition of your skin.

	SHORT-TERM	LONG-TERM	
Condition of skin?	*Dry, variable, somewhat oily, damp*	*Dry, variable, somewhat oily, damp*	Short-term V P K
What skin irritations?	*Dry rashes, acne, wet rashes/blisters*	*Dry rashes, acne, wet rashes/blisters*	
Other skin patterns?			Long-term V P K

8. Describe your menstrual pattern. If menopausal, describe patterns when still menstruating.

	SHORT-TERM	LONG-TERM	
Regularity	*Irregular, variable, regular*	*Irregular, variable, regular*	Short-term V P K
Quantity of flow	*Light, variable, moderate, heavy*	*Light, variable, moderate, heavy*	
Level of discomfort	*Painful, Moderate, painless*	*Painful, Moderate, painless*	Long-term V P K
How many days (of cycle & flow)	*# of days: length of cycle:*	*# of days: length of cycle:*	
PMS Symptoms, etc.			

9. Describe your sleeping patterns.

	SHORT-TERM	LONG-TERM	
Type of sleep	*Light, medium, heavy*	*Light, medium, heavy*	Short-term V P K
Ease in falling asleep	*Variable, medium, easy*	*Variable, medium, easy*	
Ease in waking up	*Easy, medium, with difficulty*	*Easy, medium, with difficulty*	
Dream patterns	*Flighty, intense, flowing*	*Flighty, intense, flowing*	Long-term V P K

MANAS–PERSONALITY

(COMBINE WITH MANAS-EMOTIONS (INTAKE 7) TO ASSESS MANAS PRAKRUTI/VIKRUTI)

1. Do you find yourself most often a leader, follower, or one who goes off on your own? Do others place you in leadership roles, do you prefer a supportive role in groups?

***V P K** ST:* _____

_____

***V P K** LT:* _____

_____

2. How do you react to stress? Overwhelm, scatter, irritable, rise to challenge. What kinds of things generate stress?

***V P K** ST:* _____

_____

***V P K** LT:* _____

_____

3. How are you at decision making? Fast, slow, indecisive, often or easily change mind once decided.

***V P K** ST:* _____

_____

***V P K** LT:* _____

_____

4. Are you more like a bumblebee, a bull or a turtle? Describe each and have them tell you how they are like the one they chose. If necessary, ask them to combine the three animals.

***V P K** ST:* _____

_____

***V P K** LT:* _____

_____

5. Describe your approach to projects. Prefer beginning, entire process, finishing? Enjoy planning or wrapping up? Number of projects going at one time? Tend toward procrastination?

***V P K** ST:* _____

_____

***V P K** LT:* _____

_____

Describe the client's overall quality of voice and manner of speaking? Fast, rambling, storyteller, clear, concise, to the point, slow, well thought out, quiet

V P K

_____

_____

*CLIENT NAME:*_____ *Section One* ***Intake 13***

Ayurvedic Physical Assessment

		Circle neatly	*Comments/observations*
Face Shape	*V P K*	*oval, angular, square, round*	
Facial Energy	*V P K*	*Delicate, subtle, passionate, intense, soft, sweet*	
Eyes	*V P K*	*small, deep set, large, moist*	
Nose (size)	*V P K*	*Small, medium, large*	
Nose (bridge)	*V P K*	*narrow, medium, wide*	
Lips	*V P K*	*Thin, medium, thick*	
Neck	*V P K*	*Long, medium, short*	
Hair traits	*V P K*	*course strands, fine strands, dry, kinky, sparse, dense, balding, early grey, oily, straight*	
Skin Thickness	*V P K*	*Thin, medium, thick*	
Skin Condition	*V P K*	*dry, rough, wrinkles, slightly oily, moles, soft, moist, oily, smooth*	
Complexion	*V P K*	*Lacks luster, pale, ruddy, rosy, radiant*	
Physique	*V P K*	*Slight, moderate, stocky, irregular, shapely*	
Bones	*V P K*	*Narrow, moderate, stocky*	
Palm of hand	*V P K*	*Square, rectangular*	
Fingers	*V P K*	*Long, narrow, medium, short, thick*	