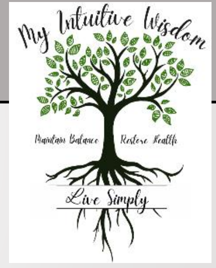
My Intuitive Wisdom



Ayurveda

Confidential Client History

Section A: Client Information

Name:		
Address:		
City, State, Zip:		
Home Phone:	Work:	Cell:
E-mail:	Date of Birth:	Age:
Marital/Partner Status:	# of Children:	Ages:
Who do you live with?		
How is the home environment for you?		
Occupation:		Number hours/week:
Does your job give you satisfaction and/or stress and why?		
How did you hear about Ayurveda?		
Why did you choose to receive an Ayurvedic Consultation?		
Notes:		

Section B: Financial Policy Agreement

1. There is a $ 295.00 charge for your 4-visit consultation package. Payment is due at the initial consultation. This includes the initial interview, report of findings meeting and two follow-up visits. Additional follow-up visits are $ 25.00 each.

2. Herbal formulas, if recommended, are at an additional cost and paid to Ayurveda Herbalist, Margaret Regan. Whatever Margaret does not handle, can be ordered from other organic sources that I will provide at that time.

3. I do not bill insurance companies for services or herbs. Payments accepted: cash, check or credit card. ** There is a 4% service fee for credit cards

4. If body therapies are recommended, payment for those services is made directly to the clinic or bodyworker at time of appointment. Ayurveda body therapies may be provided by any certified Ayurveda Bodyworker.

I have read and understand the financial policies of My Intuitive Wisdom Ayurveda.

Client Signature:	Date:

Section C: Informed Consent

Name: Virginia Van Pay

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

1. My goal 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. I am not a medical doctor.
3. I am not trained in Western medical diagnosis or treatments.
4. It is recommended that all symptoms or diseases of concern be evaluated by a medical doctor or another licensed health care professional (LHCP). If you choose not to see a LHCP, you will have to sign an acknowledgment that one was recommended to you. Additionally, certain symptoms require a medical evaluation before you may proceed with Ayurvedic care.
5. I am not able to change or alter your prescriptions. You will need to work with your medical doctor.

I have read and understand the above information.

Client Signature:	**Date:**

Section D: Past Medical History

Include major conditions, dates of treatment and procedures performed.

What serious illnesses or injuries have you had (include dates)?
What operations and prior hospitalizations have you had (include dates)?
List other pertinent past conditions including conditions such as skin issues, fibromyalgia, etc. (include dates)
For Women Only: Are you menopausal? ☐Yes ☐No Date of last period: ____________________________ If you have children, list any challenges with your pregnancy, labor and postpartum periods. List any past issues with your reproductive system including PMS symptoms, endometriosis, fibroids, miscarriages, abnormal pap smears, infertility:

Section E: Family History

Disease	Relative	Detail (if applicable)	Notes Only:
Cancer			
Stroke			
Diabetes			
Heart Disease			
Mental Disorder			
Other (explain)			

Section F: Current History

What are your goals and intentions in receiving an Ayurvedic Consultation?	
What are your current health concerns at-this-time and when did they begin? (if you need more room use an extra blank sheet)	
Are you currently under the care of a Medical Doctor or Health Care Professional? If so, for what?	
Is there a possibility that you are pregnant? ☐Yes ☐No If yes, how is your pregnancy going?	
Current Diagnosed Conditions (use additional paper if needed)	Related Medications/Treatment (medications detail in next section)

Section G: Current Medications, Herbs and Supplements

Please list any medications, herbs and supplements that you are currently taking as well as any significant remedies that you have recently stopped taking. Add additional medications on a separate page.

Name of Substance	Prescription, OTC, Herb, Vitamin, etc.	Prescribed by whom & when started taking	Purpose	Dosage	What effects have you noticed

Section H: Daily Routines

Do you subscribe to any specific diet? (vegetarian, vegan, macrobiotic, other)
Do you eat meat, chicken, fish, egg, dairy or soy?
Do you have any allergic reactions to substances or foods that you are aware of?
Describe any current or past problems with chronic eating disorders or other food related issues?
Do you drink coffee, tea, soda or juice? How many cups of each per day?
How much water do you drink per day?
If you drink alcohol, how many glasses per week and what types of alcohol?
Do you have any routines surrounding eating? Where do you eat? What does your mealtime look like – do you eat while working, on the go, while reading, watching TV or another activity; do you say blessings or grace before a meal, do you eat alone or with others, etc.?
How often do you eat out? Where/What types of food?
In cooking, what do you use primarily (put in ranking order 1, 2, 3, 4 eaten most often). - Fresh - Frozen - Canned - Organic Foods - What types of spices and condiments do you use primarily?
How is your food prepared (by another family member, out in restaurants, stove top/oven, microwave, pressure cooker, grill)?
What types/brands personal care products do you use (soap, shampoo, Deodorants, cosmetics, skin care)?

Do you have regular spiritual practices and how often do you do them? (meditation, yoga, journaling, spiritual reading, gratitude practice, religious practice such Bible study or going to church.		
Do you exercise regularly? ☐Yes ☐No Type of exercise & length of time:		
Describe any creative activities or hobbies:		
If you smoke, how many packs of cigarettes per day?		
If you smoked in the past, how much did you smoke?	When did you quit?	
Are you a past or current user of recreational drugs?		
Substance:	Amount:	When did you quit?
Substance:	Amount:	When did you quit?
How is your libido/sexual energy?		
How many hours of sleep are you getting per night?		
Do you feel well-rested with enough energy to get through your day? If not, why?		
What feels stressful or ineffective about your daily habits that you would like to work on changing?		

Section H: Routine Details, cont.

MORNING: wakeup, personal care routines, Breakfast, beverages drank, exercise routines, work, activity, commute	
5:00 am	
6:00 am	
7:00 am	
8:00 am	
9:00 am	
10:00 am	
11:00 am	
12:00 noon	
MID DAY: What time do you eat Lunch, snacks, breaks during the day, activities, beverages, leaving work, commute	
1:00 pm	
2:00 pm	
3:00 pm	
4:00 pm	
5:00 pm	
EVENING: What time do you eat your evening meal at, eating out, activities, late night eating, computer use, bedtime	
6:00 pm	
7:00 pm	
8:00 pm	
9:00 pm	
10:00 pm	
11:00 pm	
Past 11:00	

Section I: Bodily System Symptoms

For the following sections: Please check symptoms that you are **CURRENTLY** experiencing with the following details:

- **Frequency** – number of times per day, week or month (1W, D, 3M, ongoing, etc.)
- **Intensity** – a range of 1-10: 1 being the mildest, 4 being regular & strong enough to seek support, 10 being worst
- **Onset** – when the symptom started (2 months ago, 5 years ago, age 20, etc.)
- **Duration** – how long does the symptom last (constant, 20 minutes, 2 hours)
- Put Y (yes) or N (no) for **evaluated by a Licensed Health Care Practitioner** (LHCP) which means having a conversation with the appropriate health provider who has the scope of practice with such symptoms.

The shaded areas are for my use, so please disregard, as I will use those areas to track symptoms and provide my own notes.

I-1 Mind/Emotions

Current 'X'	Symptom	Frequency	Intensity 1 – 10	Onset	Duration	Evaluated LHCP?	Tracking Y/N	VPK
	Worry							
	Anxiety/Fear							
	Overwhelm							
	Spaciness							
	Self-Critical/Self Sabotaging Thoughts							
	Difficulty Remembering							
	Difficulty Focusing							
	Anger/Rage							
	Resentment							
	Jealousy/Envy							
	Being Critical of Others							
	Mental Lethargy /Slow Thinking							
	Sadness							
	Depression							
	Insomnia/Disrupted Sleep							
	Fatigue							
					Vikrti Total	V:	P:	K:

Notes:

I-2 Digestion/Elimination								
Current 'X'	**Symptom**	**Frequency**	**Intensity 1 – 10**	**Onset**	**Duration**	**Evaluated LHCP?**	**Tracking Y/N**	**VPK**
	Burning Indigestion/ Heartburn							
	Belching							
	Nausea							
	Excessive Gas (often)							
	Stomach Gurgling							
	Heaviness after eating							
	Bloating after eating; gas that can't escape							
	Colicky Pain							
	Hemorrhoids							
	Constipation (<1 BM/Day)							
	Diarrhea/Loose stools							
	Constipation/Diarrhea							
	Heat with Elimination							
	Bloody Stool							
	Anal Itching							
	Irregular Appetite							
	Intense Hunger							
	Little/Low Appetite							
					Vikrti Total	V:	P:	K:
Notes:								

Current 'X'	Symptom	Frequency	Intensity 1 – 10	Onset	Duration	Evaluated LHCP?	Tracking Y/N	VPK
I-3 Head								
	Headaches							
	Dizziness							
	Fainting Spells							
	Loss of Balance							
	Thinning/Loss of Hair							
I-4 Ears & Nose								
	Hearing Loss							
	Ringing in the Ears							
	Earaches							
	Loss of Smell							
	Nose Bleeding/Dryness							
	Nose Discharge/Post-Nasal Drip							
	Sinus Congestion							
I-5 Eyes								
	Painful/Sore Eyes							
	Red Eyes							
	Burning Eyes							
	Mucous in the Eyes							
	Puffy Eyes							
	Dry Eyes							
	Itchy Eyes							
	Eye Tics/Twitching							
	Blurred/Loss of Vision/Cataracts							
					Vikrti Total	V:	P:	K:
Notes:								

Current 'X'	Symptom	Frequency	Intensity 1 – 10	Onset	Duration	Evaluated LHCP?	Tracking Y/N	VPK
	I-6 Mouth							
	Excessive Thirst							
	Bad Breath (Halitosis)							
	Lip Ulcers/Lesions							
	Dry/Cracking Lips							
	Bleeding/ Receding Gums/ Sensitive Gums							
	Dry Mouth							
	Tooth Pain/ Jaw Pain TMJ							
	I-7 Neck							
	Pain/Stiffness							
	Swollen Glands							
	I-8 Chest							
	Chest Pain							
	Tightness/Pressure							
	Heart Palpitations							
	Shortness of Breath							
	Painful/Difficult Breathing							
	Persistent Cough							
	Frequent Chest Colds							
	I-9 Skin							
	Dry/Flaky Skin							
	Rashes							
	Acne							
	Changing/ Bleeding Moles							
	Fungus/Eczema/Psoriasis							
	Strong Smelling Perspiration							
					Vikrti Total	V:	P:	K:

Notes:

Current 'X'	Symptom	Frequency	Intensity 1 – 10	Onset	Duration	Evaluated LHCP?	Tracking Y/N	VPK
I-10 Urinary								
	Painful Urination							
	Heat with Urination							
	Urine Retention/ Dribbling							
	Frequent Urination							
	Blood in Urine							
	Kidney/Bladder Infections							
I-11 Muscles & Joints								
	Swelling in Joints							
	Pain/Ache/ Stiff in Joints							
	Muscle/Bone Pain							
	Muscle Weakness/Atrophy							
I-12 Nerves								
	Loss of Sensation							
	Tingling Sensation							
	Tremors in Limbs							
	Uncoordinated Muscles							
I-13 Circulations								
	Varicose Veins							
	Cold Hands/Feet							
	Swollen Ankles/ Calf Pain							
	Overall Feeling Cold/ Overall Feeling Warm							
	Mild Puffiness/ Water Retention in Body							
					Vikrti Total	V:	P:	K:

Notes:

I-14 Male System								
Current 'X'	Symptom	Frequency	Intensity 1 – 10	Onset	Duration	Evaluated LHCP?	Tracking Y/N	VPK
	Swollen/Painful Prostate							
	Low Sperm Count							
	Low Sperm Motility							
	Genital Sores/Lesions							
	Genital Discharge							
	Erection Difficulty							
	Genital Sores/STD							
I-15 Female System								
	Irregular Cycle							
	Heavy/Prolonged Bleeding							
	Missed Menses							
	Painful Menses/Cramps							
	Spotting/Discharge							
	PMS Symptoms: ☐ Bloating ☐ Headaches ☐ Weight Gain ☐ Irritable ☐ Breast Tenderness ☐ Weepy							
	History of Miscarriage/Infertility							
	Genital Sores/STD							
	Ovarian Cyst/Fibroids							
	Hot Flashes							
	Vaginal Itching							
					Vikrti Total	V:	P:	K:

Notes:

I-16 Other								
Current 'X'	**Symptom**	**Frequency**	**Intensity 1 – 10**	**Onset**	**Duration**	**Evaluated LHCP?**	**Tracking Y/N**	**VPK**
	Sudden weight loss							
	Sudden weight gain							
Any other symptoms you're experiencing not previously covered above								
					Vikrti Total	V:	P:	K:
Notes:								