Ayurveda + Lifestyle Intake

Client Information

Name _____
Today's Date _____

Address _____
Phone _____
Email _____

Age _____
Date of Birth _____
Gender _____

Preferred Method of Contact ___ SMS ___ Email ___ Phone

What To Expect From Your Ayurveda Consultation

Ayurveda is a system of natural healing, originating in India, that has been practiced for thousands of years. With the support of your Ayurveda Health Counselor you can begin your unique journey to wholeness through achieving balance in the body, mind, and spirit. Your Counselor may suggest changes to your lifestyle, diet, herbs, color therapy, sound therapy, and other natural therapeutics. By changing your lifestyle and living more harmoniously with nature, you will begin to create within your body the optimal environment for healing. To successfully reach goals and make positive changes it is important that you are an active participant on your path to well-being.

Please note that your Ayurveda Counselor is not a medical doctor and serves only to educate in the system of Ayurvedic wellness. Your coach is not a substitute for medical care, and will not diagnose, treat, or prescribe for disease or pathological conditions.

For specific symptoms your Counselor may recommend that your condition be evaluated by a licensed healthcare professional or Clinical Ayurvedic Specialist.

If you are under medical care or the care of another healthcare provider, your work with your Ayurveda Counselor will complement the work being done by your other providers. Please do not discontinue the use of any medications without first speaking to your physician.

The information in your intake will be held in the deepest confidence. Please fill out to the best of your ability.

My signature below acknowledges the above statements as fully read and understood.

_____ _____

Client's Signature Date

Presenting Concerns | Goals

What encouraged you to want to meet with an Ayurveda Counselor? Please continue on another page if more room is needed.

How long has this been bothering you?

What are the biggest challenges, in regard to your health and wellness, that you are experiencing right now? How long have you been experiencing them?

What do you hope to gain from your ayurveda sessions?

1)
2)
3)

Have you attempted to attain these goals in the past?

If yes, what worked for you? What did not work for you?

History of Health Concerns

We begin our understanding of self by exploring patterns, family history, and physical functions in the body. This intake serves as a starting point for understanding and shifting into greater harmony.

Are you currently working with a healthcare professional for treatment? If yes, please include details.

For how long? Are you noticing any improvement in symptoms?

Family Health History

	Myself	Mother	Father	Brothers	Sisters	Child(ren)	Spouse
Age (if living)							
Age & Cause of death (if passed away)							
Anemia							
Cancer							
Diabetes							
Epilepsy							
Glaucoma							
Hay fever/Hives/ Allergies							
Heart disease							
High blood pressure							
Kidney disease							
Mental illness							
Migraines							
Obesity							
Rheumatoid Arthritis							
Sleep Apnea							
Stroke							
Substance abuse							
Thyroid disorder							
Other							

Please this space to provide details about what you have checked in the family health history:

How would you describe your health during childhood?

Are there any past medical conditions (i.e., illness, trauma, addictions, excessive stress, or anything else) that could help us better understand your health and create a plan for lifestyle changes?

Daily Routine

Now that we have explored your current and prior health concerns and discussed a little family history, let's review your current routine in sleep, food, and relationship.

How would you describe your daily routine most days?

Is it different from your ideal routine?

Sleep

What time do you get up in the morning? Is it the same every morning?

How do you feel when you wake up in the morning (i.e., well rested, tired, etc.)?

How would you describe the quality of your sleep? Do you wake up frequently, have trouble falling asleep, experience nightmares, sleep soundly?

Do you nap during the day?

What time do you go to bed? Is it the same every night?

What does your evening look like a few hours before you go to bed?

Is there anything else you would like to share about your sleep routine?

Diet and Movement

EATING HABITS

How often do ingest these foods or substances during a typical week?

	Never	Once a Week	Multiple Times per Week	Daily	Other
Carbs(bread, pasta)					
Vegetables					
Meats					
Fruits					
Dairy Products					
Alcohol					
Coffee					
Tea					
Soda (diet/regular)					
Sugar					
Cigarettes/ Chewing Tobacco					
Recreational Drugs					

Glasses of water are you drinking per day: _____

Describe what you typically eat for:

Breakfast

Lunch

Dinner

When is your biggest meal of the day?

Describe your habits while eating (Do you eat with your full attention on food? While watching television? Sitting at the table? Do you eat quickly?)

Are you currently being prescribed any herbs or medications? Please list.

Appetite + Elimination

Are there certain tastes you crave – sweet, salty, sour, bitter, hot/spicy, oily?

_____

_____

Do you eat between meals? What do you typically snack on?

_____

_____

Are you hungry upon waking?

_____

_____

How do you feel after eating (bloated, gas, belching, sluggish, fatigue, heartburn, etc.)?

_____

_____

What most accurately describes your elimination pattern:
____ 2-3 times per day ____first thing in the morning
____ immediately after dinner ____need laxative daily
____ other (please elaborate) _____

Are your stools (check all that apply)?
____ soft ____medium ____ hard ____ don't feel complete
____ straining to go ____ painful ____ mucousy
____ once every 2-3 days ____ later in the day ____ once daily
____ multiple times per day ____ immediately after meals
____ foul smelling
____ other (please elaborate) _____

Food Relationships

Were you breastfed as a baby?

What is your earliest memory of food?

What was your mother's relationship with food while you were growing up?

What was your father's relationship with food while you were growing up?

How did your family eat when you were a child?

Describe your school lunches as a child.

What food-related behaviors were you scolded for?

What foods were used as rewards when you were young?

What is something secret you like to eat, either now or in the past?

With all of the questions about eating, do you want to eat right now? Are you hungry? Is there a disconnect between the two?

Is there anything else you would like to share about your current or past diet?

Movement

Do you travel frequently? Please describe.

Do you have a commute? How often? How long is your commute?

What sorts of exercise/movement practices do you participate in?

How often do you exercise?

How long do you exercise each time?

Rate the intensity of your exercise:
____ light ____ moderate ____ vigorous

Is there anything else you would like to share about your exercise routine?

Relationships

INTIMATE RELATIONSHIPS
Current relationship status, or most recent relationship:

If currently in a relationship, how would you describe the quality of this relationship?

How would you describe your past intimate relationships?

At what age did you first become sexually active?

Are you sexually active now (with or without a partner)?

Are you satisfied with your sex life?

Is there anything you would like to be different in your intimate relationships?

FRIENDSHIPS & SOCIAL INTERACTIONS

Describe your friendships.

How many of these friends do you consider close friends?

How often do you gather or connect with close friends?

What types of activities do you usually do together with your friends?

Describe other social interactions you regularly participate in.

Reproductive Health for Women

Connecting with nature requires us to tune into our own internal rhythms as well. Answer to the best of your ability.

MENSTRUATION
Would you consider your cycle regular? If no, please provide additional information.

Do you track your cycle?

When was the first day of your last menstrual cycle?

How long does your menstruation last?

Is your menstrual flow typically light, heavy, or moderate? Please describe.

Do you have cramping or pain? Does it vary during different parts of your cycle?

Around the time of, or during your menstrual cycle do you experience any of the following: changes in mood, weight gain, acne or rashes, cravings, fatigue, depression, anxiety, yeast, breast tenderness, bloating, intense dreams, etc.

Do you use products made of natural materials during your cycle?

Are you experiencing any symptoms of Menopause and Perimenopause (i.e., hot flashes, mood swings, difficulty sleeping, vaginal dryness, and loss of libido)?

BIRTH CONTROL

What method are you currently using for contraception?

Are you using, or have you ever used, hormonal contraceptives like the pill, patch, ring or other? Do you, or have you ever, used an IUD for contraception?

Have you ever experienced side effects while using any of the above methods of birth control?

Are you, or have you ever used any hormone replacement therapies?

PREGNANCY

Are you, or have you ever been pregnant?

Number of times you have been pregnant:

Have you ever miscarried?

Have you ever experienced complications during pregnancy, delivery, or after giving birth? Please describe in the space provided below.

The Mind

Sit for a moment and notice the rhythm of your breathing. Allow thoughts to arise. What themes do you notice about your thoughts?

HISTORY

Has anyone in your family ever been diagnosed with a mental illness?

Have you ever been treated for, diagnosed with or experienced symptoms of mental illness?

CURRENT EMOTIONAL EXPERIENCE

	Intensity	Frequency	Precipitating Event (if known)
Anxious			
Overwhelmed			
Self-destructive			
Resentment			
Anger			
Depressed			
Intense			
Melancholy			
Stubborn			
Lonely			
Irritated			
Fear			
Panic			
High level of stress			
Lethargic			
Other			

Please use this space to provide details about what you have checked above:

How well do you believe you handle stress?

What are some of the ways you currently manage stress right now?

Have you ever been addicted to any substance? What and for how long?

Work + Life

Do you currently work? What kind of work?

Do you enjoy the work you do?

How would you describe your typical schedule of major activities during the week (i.e., school, work, activities with children, etc.)?

Do you have hobbies you enjoy?

How often do you get to participate in them?

What are you most passionate about?

Are there spiritual practices, such as prayer or meditation, that are important to you?

What is your current relationship to Spirit/God/Divine/Nature? How does this relationship look for you?

Do you have other rituals or cultural practices you would like us to know about?

Prakruti Evaluation

Please know that discovering your original constitution is not about judging or labeling. It gives us an idea of what balance and harmony can look like in your unique body, mind, and spirit.

Circle the response that best fits.

Physical Structure

	Vata	Pitta	Kapha
Body Frame	Thin, ectomorphic	Muscular, mesomorphic	Stout, stocky, endomorph
Bones	Light, narrow bones and/or prominent joints	Moderate bone structure, medium	Heavy, thick
Body weight	Light or variable	Moderate, muscular	Can be overweight
Complexion/Skin	Dry, rough, cool, thin, gray	Rosy, ruddy, oily, moderate thickness	Thick, pale, moist, cool
Hair	Dry, course, curly, brittle	Fine, light in color, oily, early gray, baldness	Thick, oily, lustrous, wavy
Teeth	Irregular, crooked	Moderate, yellowish teeth	Regular, strong, white, healthy
Eyes	Small	Medium, deep-set, sharp, blue or green	Large, luxurious lashes
Nose	Narrow, small	Medium	Large, wide bridge
Lips	Thin, small, may look chopped	Medium	Thick, large
Chin	Thin, angular	Tapering, angular	Rounded, double
Neck	Thin	Medium	Thick, short
Fingers	Thin, long, narrow	Medium, square	Thick, fleshy, short
Face	Oval, thinner	Angular	High
TOTAL			

Physical Function

	Vata	Pitta	Kapha
Appetite	Variable, scanty, may have extremes	Good, strong	Steady, consistently low
Sweat/Body Odor	Little smell	Profuse with a strong smell	Profuse with a pleasant or sweet smell
Sleep	Light, uninterrupted or restless	Light to moderate, can awaken & fall asleep easily	Difficult to wake up
Digestion/Elimination	Dry, hard, varies, tendency toward gas & constipation	Soft, sometimes loose or burning, 1-3x per day	Regular, solid, sometimes sluggish
Temperature	Cold	Warm	Cool
Menses	Painful cramping, irregular cycle	Heavy flow, regular	Moderate flow, mild cramping
TOTAL			

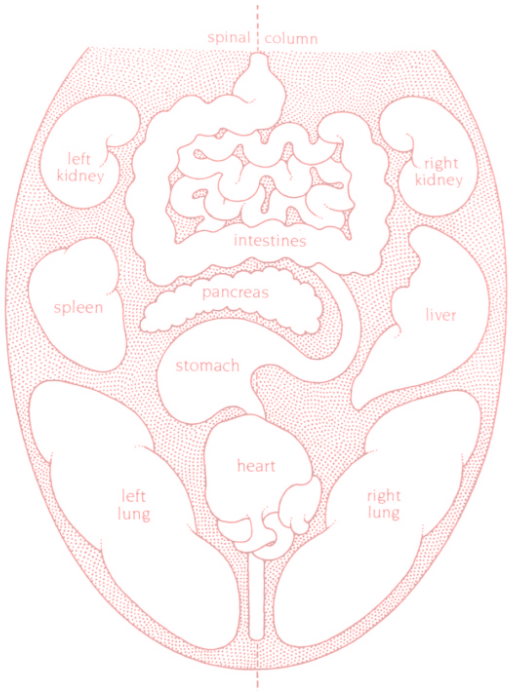
Psychological Function

	Vata	Pitta	Kapha
Mind	Restless, always active, scared, timid	Adventurous, bold	Conservative, shy
Under stress	Anxious, variable	Focused, intense	Calm, stable, conservative
Speech	Rambling, quick	Can be argumentative	Steady, slow to change
Memory	Quick to understand, quick to forget	Sharp and distinct	Slow to take notice but won't forget
Nature	Independent	Leader	Supporter
Moods	Adaptable, Playful	Courage, passionate	Love, stable, calm
Negative emotions	Fear	Anger	Attachment
Faith	Erratic, changeable, rebel	Determined, fanatic, leader	Constant, loyal, conservative
Focus	Trouble being focused	Detail-oriented	Big picture
Decision making	Trouble making choices	Quick to decide	Slow to make decisions
TOTAL			

Prakruti & Vikruti Diagnostics

Your Ayurvedic Health Counselor will examine your tongue and observe your pulse to gain more insight into your constitution.

Tongue Examination	
Size	
Shape	
Color	
Coating	
Cracks or Bumps	
Other details	



Pulse Reading			
	Vata	Pitta	Kapha
Vikruti			
Prakruti			