Ayur-Shilpi Ayurveda & Wellness Intake Form

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Name	
Date of Birth/Age	
Address	
Email Address	

1) What do you hope to achieve with your health consultation today?

2) The main problem(s) you would like help with

Describe problem	Since	Mild/Moderate/Severe	Attempted treatment and response

(Mild – some discomfort, Moderate – creates much trouble, but can continue regular activities, severe – restricts your daily routine)

3) Are you diagnosed with any medical conditions?

Condition(s)	Since when	Control status	Treating physician

4) Are you taking any prescription medications?

Medication Name	Started in	Dosage	Prescribed by

5) Are you taking any herbal or alternative medicine?

Name	Started in	Dosage	Prescribed by

6) Are you taking any vitamins or nutritional supplements?

Name with a dose of main ingredients	Since when	Regularly	Given by

7) Were there any diseases that you suffered from earlier?

Disease	From when to when	Treatment – drugs, exercise, etc.

8) Have you had any kind of surgery or minor procedures performed on you?

Procedure	When	Who and where performed

(Include any Panchakarma, Acupuncture and other treatments here as well)

9) Please list any hospitalizations.

Year	When	Procedure done

10) Family History Fill only the positive yes as 'Y' or a tick mark

	Father	Mother	Brother(s)	Sister(s)	PGF	PGM	MGM	MGF
Diabetes								

Hypertension								
Heart Disease								
Stroke								
Asthma								
Cancer (type)								
Hypothyroid								
Arthritis								
Other								
If not living, age at and cause of death								

11) How much do you move?

Activity	**Intensity**	**Hours**	**Days/ week**	**Since**

12) On a scale of 1 to 10, please indicate in the past week:

1) What is your energy level? 0 – very poor, I can barely get through the day, 10 – excellent, I can do more!

2) How hungry do you feel at different meal times? 0 – not at all 1-3 – mildly hungry 4-7 moderately hungry, 8-9 – quite hungry 10 – very hungry

13) Rate on a scale of 1-5 how the following applies
(If 1= Always, 2= Often, 3=Sometimes, 4=Rarely, 5=Never)

14) **General**

❑ Weight loss
❑ Night sweats
❑ Cravings
❑ Fatigue
❑ Sweat easily
❑ Poor sleep

❑ Change in appetite ❑ Peculiar tastes/smells
❑ Strong thirst – hot ❑ Strong thirst – cold
❑ Poor appetite ❑ Chills
❑ Tremors ❑ Poor balance
❑ Localized weakness

15) **Skin and Hair**
❑ Rashes ❑ Skin tags
❑ Itching ❑ Change in skin/hair texture
❑ Hives ❑ recent moles
❑ Loss of Hair ❑ Dandruff
❑ other skin/hair Problems ❑ Pimples

16) **Head**
❑ Dizziness ❑Migraines
❑ Facial pain ❑Headaches
❑ Other head/neck problems:

17)**Eyes, Ears, Nose, and Throat**
❑ Glasses ❑ Blurry vision ❑ Earaches
❑ Poor vision ❑ Colorblindness ❑ Poor hearing
❑ Cataracts ❑ Eye pain ❑ Nose bleeds
❑ Eye strain ❑ Spots in vision ❑ Sinus problems
❑ Night blindness ❑ Ringing in ears ❑ Teeth problems

18) **Cardiovascular**
❑ Swelling of feet ❑ Chest pain ❑ Swelling of hands
❑ Fainting ❑ Dizziness ❑ Cold feet
❑ Low blood pressure ❑ Venous swelling ❑ Difficulty breathing
❑ Difficulty breathing ❑ Blood clots ❑ Irregular heartbeat
❑ Cold hands ❑ Other problems with heart or blood vessels: ----------
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19) **Respiratory**
❑ Cough ❑ Pain with a deep breath
❑ Coughing blood ❑ Difficulty lying down
❑ Phlegm color: ❑ Other:

20) **Musculoskeletal**

❑ Neck pain ❑ Hand/wrist pain
❑ Back pain ❑ Hip pain
❑ Knee pain ❑ Shoulder pain
❑ Foot/ankle pain ❑ Muscle weakness
❑ Other muscle

21) **Gastrointestinal**

❑ Nausea ❑ Gas
❑ Vomiting ❑ Belching
❑ Diarrhea ❑ Indigestion
❑ Constipation ❑ Bad breath
❑ Blood in stools ❑ Chronic laxative use
❑ Black stools ❑ Other problems with stomach or intestine
❑ Abdominal pain/cramps ❑ Chronic laxative

22) **Genito – Urinary**

❑ Frequent urination ❑ Urgency to urinate
❑ Pain on urination ❑ Unable to hold urine
❑ Blood in urine ❑ Kidney stones
❑ Decrease inflow ❑ Impotency
❑ Excessive sexual urge
❑ Wake up to urinate how often:

23) **Neuropsychological**

❑ Lack of coordination ❑ Areas of numbness
❑ Easily susceptible to stress ❑ Poor memory
❑ Treated for emotional problems ❑ Anxiety
❑ Depression ❑ Concussion
❑ Bad temper ❑ Dizziness
❑ Seizures ❑ Loss of balance

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date:
We keep medical records of the health care services we provide for you. You may ask to see and copy your records. You may ask to correct your records. Your records will be kept confidential unless you give us written permission to release them or we are required to do so by law.
We will ask you to sign a consent form allowing us to use and disclose your health information for purposes of consultations, payment and health technique operations in this office. You may see your records or get more information about them by contacting our office.
For more information about our privacy practices please inquire with us.
By signing below, I acknowledge receipt of the Notice of Privacy Practices.

Sign and print your name here

_____ _____

Informed Consent:

I understand the approach to health and wellness offered at **Ayur-Shilpi Ayurveda & Wellness**. I understand that treatments that may be offered to me are considered complementary/Alternative and I am choosing to participate in this approach and the treatments offered.

Legal Consent for Ayurvedic Services or Therapies

I hereby request and voluntarily consent to the performance of Ayurvedic Consultation and/or Therapy, counseling, and recommendations for myself by Practitioner(s) at **Ayur-Shilpi Ayurveda & Wellness**.

I understand that methods or therapies may include but are not limited to Ayurvedic Therapies, herbal recommendations, health counseling, and food counseling. I understand that Ayurvedic Medicine is a form of holistic health care which may include health and nutritional counseling as well as therapies which aim to address imbalances in the body and mind. I understand that Shirodhara, Panchakarma and other service offerings are forms of natural Ayurvedic therapy which may be contraindicated under certain conditions, specifically improper digestion. I acknowledge these contraindications.

I understand that Ayurvedic Medicine is a safe method of addressing imbalances of the body-mind and their root cause but that may on occasion result in the temporary surfacing of uncomfortable emotions and/or sensations including changes in perceived body temperature, dizziness, tingling, pain, or numbness as the body-mind seeks a state of balance. I understand that these occurrences are a natural part of the process of the body-mind reaching a state of balance. I also understand that there is always a possibility of an unexpected complication. I understand that no guarantee can be made concerning the results of the therapy.

If Pregnant, I must notify the Practitioner immediately so that I can be informed of the possible risks and contraindications of therapy while pregnant.

I understand that the evaluation given to me is either an energetic assessment of the functioning of the Chakras and energy state of the body according to the balance of the three doshas, their qualities (gunas), the dhatus (tissues), the srotas (channels), and the malas (wastes) of the body; the causal factors for imbalance (poorvarupa and rupa), and their course of imbalance (samprapti) according to Ayurvedic Medicine. It in no way purports to be nor replaces allopathic (western) medical evaluation, diagnosis, or treatment. I understand that the practitioner(s) Shilpika Devaiah at **Ayur-Shilpi Ayurveda & Wellness** is neither a licensed physician nor a Medical Doctor and does not diagnose or treat medical conditions.

I have been advised to consult a licensed physician for any medical problems I may have and, in the event that I am receiving other conventional medical treatment, I have been advised to inform my physician of the proposed complementary therapies. In addition, I have been advised to consult a physician if a new symptom should arise. If there is a worsening of my ailment or condition or it does not improve within the time estimated by my practitioner, I am aware that I should consult a physician. I understand I am fully responsible for all decisions I make regarding whether and when to seek medical treatment.

I understand that I may refuse or stop therapies and consultations at any time. Individual experiences and diagnosing techniques may vary from person to person. Not all therapies and supplements are advisable for all clients. I have read, or have had read to me the contents of this consent in its entirety. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover all interactions, consultations, courses, Therapies and recommendations for my present condition and for any future condition(s) for which I may seek advice.

Missed Appointment Policy: I agree to inform Ayur-Shilpi Ayurveda & Wellness for any missed or forgotten appointment with a 12-hour notice.

Payment Policy: I agree to pay all charges incurred for services rendered at the time of visit or consultation.

Payment Methods Accepted:

• Cash

• Credit Cards (All Major Credit Cards)

- Consent & Hold Harmless Agreement*

☐ By checking this box and clicking SEND below, you agree to all the contents of Ayur-Shilpi Ayurveda & Wellness Consent Document and further agree to hold Ayur-Shilpi Ayurveda & Wellness and/or the Practitioner harmless of any unforeseen circumstances or complications that may arise, directly or in-directly from seeking our services. Please note: You will be asked to sign a paper copy of this consent form upon arrival. Thank you!

I have read and understand the above information and give my permission to begin a program of Ayurvedic Health care with **Ayur-Shilpi Ayurveda & Wellness LLC.**

Client's Signature, Date: _____
Client's Name (Please Print): _____
Guardian's Signature (if applicable), Date: _____
Guardian's Name (Please Print): _____