



Health Seeker Intake form

These forms are indicative of the nature of questions and flow. Actual dimensions and spacing suggested are different.

Today's Date:		Age:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M
Name (Last, First, MI):		Height:	Weight:
Address (No. Street):		Date of Birth:	Place of Birth
City, State, Zip Code:		Phone C	h w
E-mail:	Occupation:	<input type="checkbox"/> Married <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Single <input type="checkbox"/> Cohabiting <input type="checkbox"/> Widowed	
Emergency Contact Name:		Referred by:	
Phone:			

What is your ethnicity?

- | | | | |
|------------------|-------------|-----------|-------------------|
| Native American | Asian | Hispanic | Mediterranean |
| African American | South Asian | Caucasian | Northern European |
| Other | | | |

With whom do you live? *Include children, parents, other occupants, and pets with ages*

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

Main problem(s) you would like help with

Describe problem	Start date	Mild/Moderate/Severe	Attempted treatment and response

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

Are you diagnosed with any medical conditions?

Conditions	Start date	Control status	Treating physician, affiliation

Are you taking any prescription medications?

Medication Name	Start date	Dosage	Prescribed by

Are you taking any herbal or alternative medicine?

Name	Start date	Dosage	Prescribed by

Are you taking any vitamins or nutritional supplements?

Name with dose of main ingredients	Start date	Regularity	Given by

e.g., One a Day, Centrum, other vitamins

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

	Father	Mother	Brother(s)	Sister(s)	PGM	PGF	MGM	MGF
Diabetes								
Hypertension								
Heart Disease								
Stroke								
Asthma								
Cancer (type)								
Hypothyroid								
Arthritis								
Other								
If not living, age of and cause of death								

PGM, PGF = Paternal grandmother, grandfather; MGM, MGF =maternal grandmother, grandfather

Were there any diseases that you suffered from earlier?

Disease	Start and end date	Treatment – drugs, exercise, etc.

Include major infections like typhoid, malaria, hepatitis

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

Procedure	Date	Who and where was it performed

Include any Panchakarma, Acupuncture and other treatments here as well

Please list any hospitalizations

Year	Condition	Procedure done

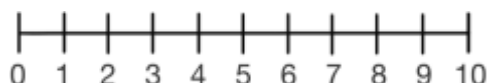
How much do you physically move your body?

Activity	Intensity	Hours	Days/ week	Start date
How often do you break a sweat with exercise? (times/week)				
How many hours do you watch TV every week?				
Do you watch TV, read or surf while eating meals?				

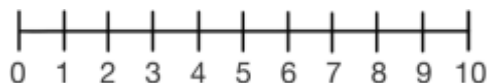
Do you connect with yourself? How and how often? Hobbies/music/ meditation/ community service etc.

On a scale of 1 to 10, please indicate for the past week:

How stressed you have been? 0 – not at all, 10 extreme

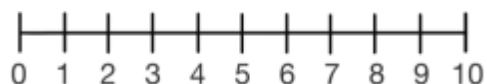


What is your energy level? 0 – very poor, I can barely get through the day, 10 – excellent, I can do more!



Rate on a scale of 0 to 10, 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!



	Example	Morning	Mid-morning	Lunch	Snack	Evening	Dinner	Bedtime
Time	11am							
How hungry	8							

Rate on a scale of 1-5 how the following applies

If 1= Always, 2= Often, 3=Sometimes, 4=Rarely, 5=Never

	Rate	If 3 or below, it indicates
Is the above pattern mentioned irregular?		<i>Vāta (Vishama)</i>
Can you skip meals easily?		<i>Kapha/Āma (Manda)</i>
Are you mostly always ready to eat – whatever the time of the day it maybe?		<i>Pitta (Tikshna)</i>
If hunger is not gratified, do you feel uncomfortable or irritable?		<i>Pitta (Tikshna)/ (Vāta)</i>
Do you end up feeling fuller earlier than expected at the start of a meal?		<i>Āma/ Vāta (Manda/Vishama)</i>
Are there times when even little quantity of food doesn't get digested for a long time?		<i>Āma (Manda)</i>
Does your food get digested well on some days and sometimes not?		<i>Vāta (Vishama)</i>

Habits Please indicate usage: none, light, moderate, or heavy. Add comments where significant.

	Heavy	Moderate	Light	None	Comments
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Personal preference

Which weather do you prefer?	Warm / cool/ both
Which extreme of weather are you unable to tolerate?	Hot / Cold / Neither
Which taste do you prefer?	Sweet/ Sour/ Salty/ Hot/ Bitter/ Astringent
How thirsty do you feel?	Often/ Moderate/ Not much
Do you sweat easily?	Often/ Not that much/ rarely

Please indicate below any symptoms you have experienced in the last three months:

General

- | | | | |
|---|---------------------------------------|--|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Fevers | <input type="checkbox"/> Sudden energy drop |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Chills | <input type="checkbox"/> <i>Time(s) of day:</i> |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Tremors | |
| <input type="checkbox"/> Peculiar tastes/smells | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Poor balance | |
| <input type="checkbox"/> Strong thirst – hot | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Localized weakness | |
| <input type="checkbox"/> Strong thirst – cold | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Bleed/bruise easily | |

Skin and Hair

- | | | | |
|------------------------------------|--|---------------------------------------|--|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Change in skin/hair texture | <input type="checkbox"/> Recent moles | <input type="checkbox"/> Other skin/hair problems: |
| <input type="checkbox"/> Skin tags | | <input type="checkbox"/> Loss of hair | |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Hives | <input type="checkbox"/> Dandruff | |
| | <input type="checkbox"/> Pimples | | |

Head

- | | | |
|--------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other head/neck problems: |
| <input type="checkbox"/> Facial pain | <input type="checkbox"/> Headaches | |

Eyes, Ears, Nose and Throat

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Color blindness | <input type="checkbox"/> Earaches | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Sore on lips or tongue |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Spots in vision | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Jaw clicks |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Teeth problems | |

Cardiovascular

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Swelling of feet | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Other problems with heart or blood vessels: |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold hands | |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Swelling of hands | |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Venous swelling | <input type="checkbox"/> Cold feet | |

Respiratory

- Cough Pain with deep breath Phlegm color: Other:
 Coughing blood Difficulty lying down

Musculoskeletal

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

Gastrointestinal

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

Genito – Urinary

- Frequent urination Urgency to urinate Kidney stones Do you wake
 Pain on urination Unable to hold urine Impotency up to urinate,
 Blood in urine Decrease in flow Excessive how often?
sexual urge

Neuropsychological

- Lack of coordination Depression Seizures Other:
 Easily susceptible to stress Bad temper Concussion _____
 Areas of numbness Poor memory Dizziness _____
 Treated for emotional Anxiety Loss of balance

Pregnancy and Gynecology

- | | | |
|---|--|---|
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Use birth control
<i>Type:_____How long: _____</i> | <input type="checkbox"/> Age at first menses:
_____ |
| <input type="checkbox"/> Clots | <input type="checkbox"/> No. of pregnancies: _____ | <input type="checkbox"/> Date of last menses:
_____ |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> No. of births: _____ | <input type="checkbox"/> Menses duration:
_____ |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> No. of premature births: _____ | <input type="checkbox"/> Length of full cycle:
_____ |
| <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> No. of miscarriages: _____ | <input type="checkbox"/> Date of last PAP: _____ |
| <input type="checkbox"/> Breast lumps | <input type="checkbox"/> No. of abortions: _____ | |
| <input type="checkbox"/> Premenstrual symptoms | | |
| <input type="checkbox"/> Unusual character (heavy or light) | | |



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.

Signature of Rogi or Legal Representative

Date

By checking this I certify that typing my name is equivalent to my signature.



Name: _____ Date: _____

Welcome to Kerala Ayurveda Academy and Wellness Center. As you know, we are practitioners, faculties, and interns of Ayurveda. We are not licensed physicians, nor are Ayurveda services licensed by the state. Ayurveda is the 5000-year-old Wisdom of Healthy living. It is a way of natural healing and emphasizes on Maintaining the harmony of Body-Mind- Spirit through diet, lifestyle, and natural herbs. In Ayurveda the emphasis is not n a disease but on maintaining the balance of individual Body Constitution, so Ayurvedic treatments are never one size fits all, but they are custom tailored for each individual need. We are primarily a training institution and the services the wellness center provide are for education purposes. As a training institution our practitioners, faculties, and interns of Ayurveda, will provide you with the following kinds of services:

- Body- Constitutional Analysis
- Diet and the Lifestyle Counseling
- Ayurvedic Body Techniques
- Yoga and Meditation Practices

Our method of treatment in Ayurveda is alternative or complementary to conventional medicine. If you ever have any concerns of your Ayurvedic practices, please feel free to discuss them with us. We recommend that you inform your medical doctor that you are receiving Ayurvedic advice.

I have read and understood the above disclosure about the Ayurvedic services offered by practitioners of Kerala Ayurveda and Wellness Center. I have disclosed with hem the nature of the services to be provided. I understand that the practitioners, faculties, and interns are not licensed physicians and the Ayurvedic services are not licensed by the state. I understand it is my responsibility to maintain a relationship for myself with a medical doctor.

Signature

Date

By checking this I certify that typing my name is equivalent to my signature.