AYURVEDA CLIENT INTAKE FORM

Name: _____ Date of Birth: _____

Occupation: _____

Address: _____

City: _____ Country: _____

Zip: _____ Phone: _____

Email: _____

EMERGENCY CONTACT

Name: _____ Phone: _____

HEALTH HISTORY

Are you currently under the care of a Health Care Practitioner? ☐ Yes ☐ No

If yes, Name: _____ Phone: _____

Do I have permission to contact your doctor? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Do you have any allergies? ☐ Yes ☐ No

If yes, what: _____

Are you taking any medications? ☐ Yes ☐ No

If yes, what: _____

Recent Surgeries: _____

Recent Accidents: _____

Major Illnesses: _____

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CURRENT OR PREVIOUS SYMPTOMS / PROBLEMS

Please select any symptoms or problems that you are currently experiencing or have experienced. This information helps your practitioner treat you more effectively and efficiently.

- ☐ SKIN DISEASE
- ☐ HEADACHES
- ☐ INSOMNIA
- ☐ ALLERGIES
- ☐ ARTHRITIS
- ☐ DIGESTIVE PROBLEMS
- ☐ COMMUNICABLE DISEASE
- ☐ ELIMINATION PROBLEMS [TOILET]
- ☐ KIDNEY DISEASE
- ☐ HEART PROBLEMS
- ☐ BACK PROBLEMS
- ☐ ULCERS
- ☐ BLOOD CLOTS
- ☐ BLOOD PRESSURE - HIGH/LOW
- ☐ FRACTURES
- ☐ JOINT PROBLEMS
- ☐ CANCER
- ☐ DIABETES
- ☐ HIV/AIDS
- ☐ TORN CARTILAGE
- ☐ VARICOSE VEINS

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

1) What is your energy level? 0 = very poor, 10 = excellent _____

2) How hungry do you feel at different meal times? 0 = not at all, 10 = very hungry _____

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

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

General

- ☐ Weight loss
- ☐ Fatigue
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Cravings
- ☐ Poor sleep
- ☐ Change in appetite
- ☐ Peculiar tastes/smells
- ☐ Strong thirst - hot
- ☐ Strong thirst - cold
- ☐ Poor appetite
- ☐ Chills
- ☐ Tremors
- ☐ Poor balance
- ☐ Localized weakness

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Skin and Hair

- [ ] Rashes
- [ ] Skin tags
- [ ] Itching
- [ ] Change in skin/hair texture
- [ ] Hives
- [ ] Recent moles
- [ ] Loss of Hair
- [ ] Dandruff
- [ ] Other skin/hair problems
- [ ] Pimples

Head

- [ ] Dizziness
- [ ] Migraines
- [ ] Facial pain
- [ ] Headaches
- [ ] Other head/neck problems

Eyes, Ears, Nose, and Throat

- [ ] Glasses
- [ ] Blurry vision
- [ ] Earaches
- [ ] Poor vision
- [ ] Color blindness
- [ ] Poor hearing
- [ ] Cataracts
- [ ] Eye pain
- [ ] Nose bleeds
- [ ] Eye strain
- [ ] Spots in vision
- [ ] Sinus problems
- [ ] Night blindness
- [ ] Ringing in ears
- [ ] Teeth problems

Gastrointestinal

- [ ] Nausea
- [ ] Gas
- [ ] Vomiting
- [ ] Belching
- [ ] Diarrhoea
- [ ] Indigestion
- [ ] Constipation
- [ ] Bad breath
- [ ] Blood in stools
- [ ] Chronic laxative use
- [ ] Black stools
- [ ] Other stomach/intestine problems
- [ ] Abdominal pain/cramps

Have you ever received Professional Massage or other body work? ☐ Yes ☐ No

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What would you like to achieve during your stay?

List your stress reduction and exercise activities:

Anything else you would like to share with the doctor:

Privacy & Confidentiality

All personal and health information provided will be treated as strictly private and confidential and used only to prepare and provide your personalised Ayurvedic programme.