Presence of Wellness
Client Intake form

All information contained here is confidential and will not be released to any person except with your written permission.

Name: _____Gender: _____

Address: _____

Home Phone: _____ Cell:_____. Best contact? cell/home

Email: _____

Preferred method of Communication:_____

Date of birth: _____ Age at time of intake: _____ Height: _____Weight: _____

Occupation: _____Number of Years:_____

Do you like your job?_____

Do you have a lengthy commute?_____

Family Status: Married _____ Separated _____ Widowed _____ Single _____

Do you have Children? Yes _____ No _____ If yes, how many and what are their ages?

_____

Are you currently under the care of a family physician or any other health practitioner? If so, please provide details._____

_____

Please list your three biggest health concerns that you would like to be free of in order of their importance. Which one do you consider to be of most concern?

How did you learn about Presence of Wellness?

_____

_____

Why are you interested in an Ayurvedic Consultation?

_____

_____

Health History (Past Serious Illnesses or accidents, date and treatment)

Condition	Date	Treatment

Current Supplements

Name	Brand Name	What is it for?	Dose	Frequency

Family Health History: *(Family or hereditary conditions)*

Mother_____

Father _____

Grandparents_____

Siblings_____

Current Medications

Name	Brand Name	What is it for?	Dose	Frequency

Have you taken many antibiotics throughout your life? _____

Reason for taking antibiotics? _____

For how long? _____

DO YOU EAT THE FOLLOWING FOOD GROUPS?

Food groups	Daily	Weekly	Monthly	Never
Grains / Cereals				
Vegetables				
Fruits				
Dairy				
Eggs				
Poultry				
Meat				
Seafood				
Sugar / Honey				
Desserts				
Juices				
Other				

How many meals do you eat each day? _____

Please describe your normal food day:

Breakfast:_____

Lunch: _____

Dinner: _____

Snacks: _____

Are you vegetarian or vegan? _____ If not, do you eat meat every day? _____

What type? _____ How often do you eat meat in a week? _____

Are you underweight or overweight? _____ By how much? _____

What is your body build? __Thin __Large __Average __Muscular

Do you eat when hungry or just because it is mealtime? _____

How many cups per day of coffee? _____ Tea? _____ Fruit Juice? _____ Soda? _____

Do you experience extreme thirst? Yes _____ No _____

How much water do you drink each day? 1-3 cups____ 4-6 cups____ 6+ cups____ None_____

Do you drink iced water or iced drinks? Yes _____ No _____

Do you drink tap water? _____ Bottled water? _____ Filtered Water? _____

Do you drink (any beverage) before a meal? ____ During a meal? ____ After a meal? _____

Do you drink alcohol before a meal? _____ During a meal? _____ After a meal?_____

Do you eat canned food? _____ Frozen food? _____ Fast food?_____

Do you eat while driving? Yes _____ No _____

Do you eat while watching television? Yes _____ No _____

Do you eat late at night? Yes _____ No _____

Do you eat hurriedly? Yes _____ No _____

Do you have any food sensitivities or allergies? Yes _____ No _____ If yes, please list those allergies/sensitivities and their duration._____

_____

_____

Do you generally eat at home? ___ At restaurants? _____ From fast food outlets? _____

Do you feel heavy or light after eating?_____

Do you take a nap after lunch or dinner? Yes _____ No _____

Do you wake up with the taste of yesterday's food in your mouth? Yes _____ No _____

Do you consider your digestion to be:

_____ Erratic _____ Sluggish _____ Good _____ Too good_____ Balanced

Do you tend to feel "bloated and/or gassy" after meals?_____Yes _____No_____

Do you regularly experience constipation? _____Yes_____No Diarrhea? ____Yes _____ No

How are your bowel habits? Please note frequency and time of day.

_____1x per day _____2x per day _____2+ x per day _____1 per 2-3 days _____ 1 per week

Are your bowels: _____Loose or runny _____Hard _____Pebble-like ____Medium consistency

Do you experience any of the following symptoms regularly?

_____Heartburn _____Nausea _____ Bad Breath _____Ulcers _____ Bloating _____Cramps

Do you have any food Intolerances? If yes what?_____

Other Substances

Did you or do you used tobacco? Yes _____ No _____ In what form? _____

Do you use alcohol? Yes ___ No ____ In what form and how often? _____

Do you use recreational drugs? Yes ____ No ____ In what form and how often? _____

Do you have use organic cleaners when you clean your home? _____

Life Routine

What time do you generally go to bed at night?_____

Do you fall asleep easily? _____

Do you sleep through the night? _____

At what time do you awaken in the morning? _____

How do you feel upon waking? ___Tired ____Refreshed ___Sluggish

Do you exercise regularly? _____Yes ____No If yes, type of exercise and frequency_____

_____

Have you exercised regularly in the past? _____Yes _____No If yes, type of exercise and reason you stopped_____

_____

Do you have sports related injuries that cause you difficulty? _____

_____

Sensory Evaluation

How is your hearing? _____

Do you have any ringing in the ears? _____ Partial or full deafness? _____

Do you have or have you ever had frequent ear infections? Yes_____ No _____

How is your eyesight? Do you wear corrective lenses? Yes_____ No _____

What taste(s) do you like or crave?

__Sweet __ Salty __ Bitter __ Sour __ Hot/Spicy __ Starches __Oily

Do you (or have you in the past) experienced any loss of your ability to taste or smell? Please describe._____

_____

Emotional Health

How are your family relationships? __Excellent __Good __ Fair __Poor

How is your social life? __Excellent __Good __ Fair __Poor

How is your mental status? __Excellent __Good __ Fair __Poor

Do you regularly experience stress or anxiety in your daily life?_____Yes _____Not too often

What do you do to offset this stress?_____

_____

Are you able to express your feelings and emotions easily? __Yes __ No

Do you experience nervousness? ___Yes ___No under what conditions?

_____

If you are married, do you feel supported by your partner?_____

How is your career? __ Love it __ Like it __ Can stand it __ Would leave tomorrow

How purposeful is your life? __Completely __ Somewhat __Neutral __Not Very

Do you have a good support system among friends and family? _____Yes _____No

Rate your spiritual life: __Fully satisfying __Somewhat satisfying __Neutral __Empty

<u>For Men only</u>:

Do you have any problems with?

__Hernias __ Testicular masses __Sexually activity __ Sexual difficulties
__ Prostate problems __Venereal disease __Discharge or sores __Problems urinating
__*Low Libido* __ Excessive Libido __Erectile problems __Tenderness
__*Infertility* __*Impotence*

<u>For Women Only</u>:

Age menses began: ……..
Which of the following describes your menstruation? (You may choose more than one)

__Regular __Irregular __Too frequent __Absent __Ceased due to menopause

How many days does your menstrual period last? __*Zero to four days* __*Five to seven days* __ *More than seven days* __ *Spotty irregularly throughout the month* __ *Other, please explain*_____

How is your menstrual flow? __Heavy __Light __ Normal __Abnormal vaginal discharges

Do you suffer from PMS? ____Yes ____No _____Mildly _____Moderately ____Miserably

Associated symptoms (before or during menstruation): ___Cravings ____Mood Swings __None __Pain __Fluid retention __Migraine __Depression __Acne __Tension __Anger __Frustration __Loneliness __Nightmares __Suicidal tendency __Other, please specify _____

Do you have any sexual difficulties? _____Yes _____No

Do you experience low libido? _____Yes _____No

If yes to either, please explain _____

Are you pregnant now? _____ Yes _____No _____Don't know

Do you take contraceptive pills or use other contraceptive devices? ___Yes ___ No If yes, What type?_____

Do you self-exam breasts regularly? _____

Do you experience any problems in your breasts? ___Lumps ___ Pain or tenderness ___ Nipple discharge ___ Others. Please explain. _____