Holistic Intake Form

THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON EXCEPT WHEN YOU HAVE AUTHOURIZED US IN WRITING TO DO SO. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE.

Section A……..Basic information (health history, symptoms, lifestyle)

Section B……..Symptom Survey is used to categorize symptoms in relation to body systems and is also used to monitor progress.

Section C and D……Metabolic/Ayurvedic Evaluation and assessing potential need for homeopathy and/or bodywork. Also gives clues as to what stress reduction techniques and lifestyle changes can be implemented into your wellness plan (detailed in your *Report of Findings* and reviewed within the second consultation). NOTE: It is NOT necessary to complete sections B and C if only operating under the option A (standard consultation) basis.

PATIENT INFORMATION

Full Name: _____ Date: _____

Date of birth _____ Age _____ Gender: Male Female

Full Mailing Address: _____

_____

Telephone number: (home):_____ (work):_____

(mobile): _____ Email: _____

May we leave you phone messages in regards to your appointments or orders? Y / N

May we e-mail you upcoming events and specials? Y / N

Marital status_____ Occupation _____

Nature of work_____

Emergency contact: Name: _____

Phone number:_____ Relation:_____

Who may we thank for referring you to our clinic: _____

CONSULTATION INFORMATION

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptoms has been present.

Problem	Onset	Diagnosis	Frequency	Severity
e.g. Headaches	June 2007	July 2009	4 times per week	Mild / moderate / severe
1.				
2.				
3.				
4.				
5.				
6.				

When was the last time you felt well? _____

Which of the following have you used? Please mark with a "C" those that you currently use. Include amount, frequency, and duration of use.

☐ Hormones ☐ Steroids ☐ Cortisone ☐ Tylenol	☐ Antacids ☐ Sedatives ☐ Laxatives ☐ NSAID's
Specify any other over the counter drugs:	

CURRENT MEDICATIONS

List all current prescription medications and supplements:

Drug/supplement (Name & What it is for):	Dosage:	Length of time taken:

List all PAST prescribed medications that you've taken for longer than 3 months:

List any prescribed medication you've had an adverse reaction to in the past.

Drug	Reaction

CHRONOLOGICAL HEALTH HISTORY

This sort of health history helps to establish trends in a person's health that may be relevant to present conditions. Indicate below any accidents, broken bones, falls, illnesses, hospitalization, surgeries, and any emotional traumas such as deaths, loss of jobs, divorces, etc.

Year 1	5
Year 6	10
Year 10	15
Year 16	20
Year 21	25
Year 26	30
Year 31	35
Year 36	40
Year 41	45
Year 46	50
Year 51	55
Year 55	60
Year 61	65
Year 66	70
Year 71	75
Year 76	80

Place mark any health problem(s) your family has suffered with either now or in the past. *Please mark anything that also applies to you!*

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other/self
Age (if still alive)												
Age at death (if deceased)												
ADD/ADHD												
Allergies												
Alcohol Abuse												
ALS or other Motor Neuron Diseases												
Alzheimer's												
Anemia												
Anxiety												
Arthritis												
Asthma												
Autism												
Autoimmune Diseases (such as Lupus)												
Bipolar Disease												
Bladder disease												
Blood clotting problems												
Bowel disease												
Celiac disease												
Chronic fatigue												
Chronic swollen glands												
Dementia												
Depression												
Diabetes												
Eczema												
Emphysema												
Environmental Sensitivities												
Epilepsy												
Flu												
Food Allergies, Sensitivities, Intolerances												
Genetic disorders												
Glaucoma												
Gum/teeth problems												
Headache												
Heart Disease												
High Blood Pressure												
High Cholesterol												
Hives												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)												

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmothe	Paternal Grandfather	Aunts	Uncles	Other/self
Inflammatory Bowel Disease												
Insomnia												
Irritable Bowel Syndrome												
Kidney disease												
Multiple Sclerosis												
Nervous breakdown												
Obesity												
Osteoporosis												
Other												
Overweight												
Parkinson's												
Pneumonia/Bronchitis												
Psoriasis												
Venereal disease, please specify_____												
Recreational Drug use												
Seizures												
Schizophrenia												
Sleep Apnea												
Smoking addiction												
Stroke												
Substance abuse (such as alcoholism)												
Ulcers												

1. How many times have you been treated with antibiotics in the past 5 years? Circle: 0 1-3 3-6 +
2. Mothers state of health during her pregnancy with you, if you know?

_____
_____

3. How was your birth? Any complications?_____
4. How long were you nursed? _____
5. How often do you get the common cold? _____ How long does it last? _____
6. Does it tend to settle anywhere in particular (head/neck, chest/lungs, sinuses, etc.)?_____
7. How would you rate your health on a scale of 1-5 (5 being excellent): _____
8. Do you take full responsibility for your health? YES NO Somewhat
9. Blood type:_____
10. Date of last physical exam: For what reason?_____
11. Do you get regular SCREENING TESTS done by another doctor? (Pap, blood test, etc.) Y/N
12. Do you use alternative practitioners?_____
    Have you ever been anemic? Yes or No
13. Have you ever been noticeably malnourished? Yes or No
14. Have you ever struggled with eating disorders? If so please list when it started and how long:_____
15. Do you have any of the following:

☐ Amalgam fillings (silver)
☐ Root canal
☐ Periodontal disease
☐ Other dental work

_____
_____
_____

PERSONAL HEALTH HABITS

Have you made any changes in your eating habits because of your health? Yes____ No_____
Do you currently follow a special diet or nutritional program? Yes____ No_____
Check all that apply:

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ High protein
- ❑ Vegetarian
- ❑ Vegan
- ❑ Gluten restricted
- ❑ Low sodium
- ❑ Fat restriction
- ❑ Low starch/carbohydrate
- ❑ The Blood type Diet
- ❑ Metabolic Typing Diet
- ❑ The Zone Diet
- ❑ Total calorie restriction
- ❑ Diabetic
- ❑ No dairy
- ❑ Specific Program for Weight Loss/Maintenance Type:_____

Please check any specific food restrictions you have:

- ❑ Dairy
- ❑ Soy
- ❑ Wheat
- ❑ Corn
- ❑ Eggs
- ❑ All gluten
- ❑ Other_____

Is there anything special about your diet that I should know?

_____

Height (feet/inches)_____

Current Weight_____

Usual weight range +/- 5 lbs_____

Desired Weight range +/- 5 lbs_____

Highest adult weight _____

Lowest adult weight _____

Weight fluctuations (>10lbs) Yes_____ No _____

How often do you weigh yourself:_____

Are there any foods that you avoid because they give you symptoms? Yes____ No_____

If yes, please name the food and symptom e.g. wheat – gas and bloating

Food	Symptom	Other comments

If you could only eat a few foods a week, what would they be?

_____

How many meals do you eat out per week? 0-1_____ 1-3____ 3-5____ >5_____

Check all the factors that apply to your current lifestyle and eating habits:

- ❑ Fast eater
- ❑ Erratic eating habits
- ❑ Eat too much
- ❑ Late night eater
- ❑ Dislike health food
- ❑ Time constraints
- ❑ Eat more than 50% of meals away from home
- ❑ Travel frequently
- ❑ Non-availability of healthy foods
- ❑ Do not plan meals or menus
- ❑ Reliance on convenience items
- ❑ Poor snack choices
- ❑ Significant other or family members don't like healthy foods
- ❑ Significant other or family members have special dietary needs of food preferences
- ❑ Love to eat
- ❑ Eat because I have to
- ❑ Have a negative relationship to food
- ❑ Struggle with eating issues
- ❑ Emotional eater (eat when sad, lonely, depressed, bored)
- ❑ Eat too much under stress
- ❑ Eat too little under stress
- ❑ Don't care to cook
- ❑ Eating in the middle of the night
- ❑ Confused about nutritional advise
- ❑ Diet often for weight control

Do you have symptoms **immediately after** eating, such as belching, bloating, sneezing, hives, etc.?

Yes _____ No _____ If yes, please explain:_____

Do you feel you have **delayed** symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes _____ No _____

Do you feel **worse** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

Do you feel **better** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

Does skipping meals seem to have an effect on you? Yes _____ No _____

Do you have an aversion to certain foods? Yes _____ No _____ If yes, what food(s):

_____

CHECK ANY THAT APPLY

- ❑ Skip meals (please specify reason): _____
- ❑ Lack of appetite
- ❑ Excessive appetite
- ❑ Feel hungry shortly after eating a good-sized meal
- ❑ Nausea after meals
- ❑ Specific foods upset, specify: _____
- ❑ Sense of fullness with very little food, or delayed 2-4 hrs. after meal (please underline with one)
- ❑ Digestive problems that subside with rest and relaxation
- ❑ Swallowing difficulty or frequent choking
- ❑ Burning sensation in the lower portion of chest, especially when lying or bending down
- ❑ Burning or aching relieved by eating
- ❑ Stomach pains or burning 1-4 hrs. after meals
- ❑ Three or more bowl movements in a day
- ❑ Less than one bowl movement
- ❑ Undigested food is stools
- ❑ Pass mucus in stools
- ❑ Small, hard, or dry stools
- ❑ Bowl movement shortly after eating (within one hr.)
- ❑ Burping, bloating or gas after eating
- ❑ Lightly colored stools
- ❑ Loose stools
- ❑ Constipation
- ❑ Unexplained itchy skin, especially at night
- ❑ Easily chill, especially after eating, dizzy when rising, and/or darkness under eyes
- ❑ Consistency or form of stools (e.g., from narrow to loose) changes with in the course of the day

# of bowl movements _____. Are they well-formed, if not specify:_____

FOOD CONSUMTION

Has there ever been a food that you have craved or really "pigged out" on over a period of time?

Yes _____ No _____ If yes, what food(s) _____

What snacks do you eat or drink between:

Breakfast & Lunch:

_____

Lunch & Dinner:

_____

After Dinner:

_____

How much of the following do you consume each day/week?

ITEM	Daily	Weekly	Favorite Type
Candy			
Cheese			
Chocolate			
Cups of coffee			
Cups of tea			
Cups of hot chocolate			
Cups of juice			
Diet sodas (12-ounce can/bottle)			
Sodas (12-ounce can/bottle)			
Energy Drinks (12-ounce can/bottle)			
Ice cream			
Salty foods			
Bread (rolls/bagels)			

FOOD DIARY **Check foods/drinks that you consume a minimum of 3 days or more each week.**

- ❑ Almonds
- ❑ Almond Butter
- ❑ Alcohol
- ❑ Apples
- ❑ Avocado
- ❑ Asparagus
- ❑ Bagels
- ❑ Barley
- ❑ Banana
- ❑ Bacon
- ❑ Beans
- ❑ Bread, White
- ❑ Bread, Wheat
- ❑ Bread, Rye
- ❑ Bagels
- ❑ Biscuits
- ❑ Bean, Pinto
- ❑ Bean, String
- ❑ Broccoli
- ❑ Brazil Nuts
- ❑ Brussels Sprouts
- ❑ Blueberries
- ❑ Butter
- ❑ Cabbage
- ❑ Cereal, Special K
- ❑ Cereal, Bran flakes
- ❑ Cereal, Cornflakes
- ❑ Cereal, _____
- ❑ Cereal, _____
- ❑ Celery
- ❑ Candy
- ❑ Chinese Food
- ❑ Cream Cheese
- ❑ Carrot
- ❑ Chicken
- ❑ Clam
- ❑ Cocoa-Chocolate
- ❑ Carnation Drink
- ❑ Chewing gum, sweetened
- ❑ Chewing gum, sugar free
- ❑ Coconut
- ❑ Cod
- ❑ Coffee
- ❑ Corn
- ❑ Crab
- ❑ Cranberry
- ❑ Cashew
- ❑ Cheese
- ❑ Cucumber
- ❑ Deli Meats
- ❑ Desserts
- ❑ Deli Sandwich
- ❑ Eggplant
- ❑ Ensure
- ❑ Fast foods
- ❑ Flounder
- ❑ Fried Foods
- ❑ French Fries
- ❑ French Toast
- ❑ Garlic
- ❑ Ginger
- ❑ Grape
- ❑ Grits
- ❑ Greek Food
- ❑ Grapefruit
- ❑ Grape nuts
- ❑ Haddock
- ❑ Ham
- ❑ Halibut
- ❑ Herring
- ❑ Hot Dogs, Pork
- ❑ Hamburgers
- ❑ Honey
- ❑ Italian Food

- ❑ Ice Cream
- ❑ Indian Food
- ❑ Japanese Food
- ❑ Jelly
- ❑ Ketchup
- ❑ Lamb
- ❑ Lemon
- ❑ Lentils/Legumes
- ❑ Lettuce
- ❑ Lobster
- ❑ Mackerel
- ❑ Margarine
- ❑ Melons
- ❑ Millet
- ❑ Mung Bean
- ❑ Mushroom
- ❑ Mustard
- ❑ Milk, Cow
- ❑ Milk, Goat
- ❑ Milk, Rice
- ❑ Milk, Almond
- ❑ Milk, Soy
- ❑ Mexican Food
- ❑ NutriSweet
- ❑ Oatmeal, Regular
- ❑ Oatmeal, Instant
- ❑ Olive
- ❑ Onion
- ❑ Orange Juice
- ❑ Oyster
- ❑ Orange
- ❑ Papaya
- ❑ PopTarts
- ❑ Peanuts
- ❑ Peanut butter
- ❑ Peas
- ❑ Peach
- ❑ Pecan
- ❑ Pepper, Green
- ❑ Perch
- ❑ Pineapple
- ❑ Pancakes
- ❑ Protein Shakes: _____
- ❑ Plum
- ❑ Pork
- ❑ Peanut
- ❑ Potato, sweet
- ❑ Potato, White
- ❑ Pumpkin
- ❑ Quinoa
- ❑ Radish
- ❑ Rye
- ❑ Safflower oil
- ❑ Salt
- ❑ Salmon
- ❑ Scallops
- ❑ Sausage
- ❑ Slim Fast
- ❑ Sweet & Low
- ❑ Sesame
- ❑ Shrimp
- ❑ Snapper
- ❑ Soft Drinks
- ❑ Sole
- ❑ Sour cream
- ❑ Soybean
- ❑ Spinach
- ❑ Strawberry
- ❑ Sucralose
- ❑ Sugar
- ❑ Sunflower
- ❑ Salad Bar
- ❑ Sardines
- ❑ Squash
- ❑ Tea, Black
- ❑ Tea, Decaffeinated
- ❑ Thai food
- ❑ Tomato
- ❑ Trout
- ❑ Tuna
- ❑ Turkey
- ❑ Tangerine
- ❑ Vinegar
- ❑ Walnut
- ❑ Waffles
- ❑ Whitefish
- ❑ Wheat
- ❑ Yeast, Bakers
- ❑ Yeast, Brewers
- ❑ Yogurt
- ❑ Yam
- ❑ Zucchini

❑ **Water:** Glasses/day___ **Type**: Tap:___ Distilled:___ Spring:___ Well:___ Reverse Osmosis:___

Do you smoke? YES NO Amount/day? _____Years smoked?_____ Year stopped?_____
Are you exposed to smoking at home? YES NO Are you exposed to smoking at work? YES NO
Alcohol use? YES NO Type:_____Frequency:_____
Recreational drug use? YES NO Type:_____Frequency:_____

LIFESTYLE

1. Are you frequently exposed to animals? YES NO What type? _____
2. Are you regularly exposed to toxins or other hazards? YES NO What kind? _____
3. Do you exercise regularly? YES NO Type:_____ Frequency of exercise :_____
4. How many hours do you sleep per night? _____ Do you wake rested: YES NO
5. How many sleep disturbances? _____ How many hours do you work each day? ____ Do you do shift work? Y/N
6. What level of personal stress are you experiencing right now?
   □Minimal □Average □Considerable □Unbearable

The main stressor is:
□Financial □Job related □Marriage □Health
□Interpersonal □Unfulfilled expectations □Family □Spiritual

What do you do to deal with stress?_____
_____
_____
When was your last vacation? _____Where did you go?_____
What are your hobbies?_____

Section B

SYSTEMS SURVEY

INSTRUCTIONS: Check boxes which currently apply to you. **Mark 1-3:**
1 – Symptoms occur on occasion
2 - Occurs frequently
3 - Chronic (always present)
Mark with a "P" if occurred in the past.

1

- ❑ Get chilled often
- ❑ "Lump" in throat
- ❑ Dry mouth-eyes-nose
- ❑ Watery eyes
- ❑ Pulse speeds after meal
- ❑ Keyed up - fail to calm
- ❑ Cut heals slowly
- ❑ Gag easily
- ❑ Unable to relax; startles easily
- ❑ Extremities are clammy
- ❑ Strong light irritates
- ❑ Reduced Urination
- ❑ Heart pounds after retiring
- ❑ Upset or nervous stomach
- ❑ Reduced appetite
- ❑ Cold sweats
- ❑ Fever easily raised
- ❑ Neuralgia-like pains
- ❑ Staring, blinks little
- ❑ Sour stomach

2

- ❑ Joint stiffness on arising
- ❑ Muscle-leg-toe cramps at night
- ❑ "Butterfly" stomach, cramps
- ❑ Eyes or nose water
- ❑ Eyes blink often
- ❑ Eyelids swollen, puffy
- ❑ Indigestion soon after meals
- ❑ Always seems hungry; feels "lightheaded" often
- ❑ Digestion rapid
- ❑ Vomiting frequent
- ❑ Hoarsenss frequent
- ❑ Breathing irregular
- ❑ Pulse slow; feels "irregular"
- ❑ Gagging reflex slow
- ❑ Difficulty swallowing
- ❑ Constipation, diarrhea alternating
- ❑ "Slow starter"
- ❑ Get "chilled" infrequently
- ❑ Perspire easily
- ❑ Circulation poor, sensitive to cold
- ❑ Subject to colds, asthma, bronchitis

3

- ❑ Eat when nervous
- ❑ Excessive appetite
- ❑ Hungry between meals
- ❑ Irritable before meals
- ❑ Get "shaky" before meals
- ❑ Fatigue, eating relieves
- ❑ "Lightheaded" if meals delayed
- ❑ Heart palpitates if meals missed or delayed
- ❑ Afternoon headaches
- ❑ Overeating sweets causes upset
- ❑ Crave candy or coffee in afternoons
- ❑ Moods of depression - "blues" or melancholy
- ❑ Abnormal craving for sweets or snacks

4

- ❑ Hands and feet go to sleep easily, numbness
- ❑ Sigh frequently, "air hunger"
- ❑ Aware of "breathing heavily"
- ❑ High altitude discomfort
- ❑ Opens windows in closed rooms
- ❑ Susceptible to colds and fevers
- ❑ Afternoon "yawner"
- ❑ Get "drowsy" often
- ❑ Swollen ankles, worse at night
- ❑ Muscle cramps, worse during exercise: get "charley horses"
- ❑ Shortness of breath on exertion
- ❑ Dull pain in chest or radiating into left arm, worse on exertion
- ❑ Bruise easily, "black and blue" spots
- ❑ Tendency to anemia
- ❑ "Nose bleeds"
- ❑ Noises in head, or "ringing in ears"
- ❑ Tension under the breastbone, or feeling of "tightness", worse on exertion
- ❑ Abnormal craving for sweets or snacks

5

- ❑ Dizziness
- ❑ Dry skin
- ❑ Burning feet
- ❑ Blurred vision
- ❑ Itching skin and feet
- ❑ Excessive falling hair
- ❑ Frequent skin rashes
- ❑ Bitter, metallic taste in mouth in mornings
- ❑ Bowel movements painful or difficult
- ❑ Worrier, feels insecure
- ❑ Feeling queasy; headache over eyes
- ❑ Greasy foods upset
- ❑ Stools light colored
- ❑ Skin peels on foot soles

- ❑ Pain between shoulder blades
- ❑ Use laxatives
- ❑ Stools alternate from soft to watery
- ❑ History of gallbladder attacks or gallstones
- ❑ Sneezing attacks
- ❑ Dreaming, nightmare type bad dreams
- ❑ Bad breath (halitosis)
- ❑ Milk products cause distress
- ❑ Sensitive to hot weather
- ❑ Burning or itching anus
- ❑ Crave sweets

6

- ❑ Loss of taste for meat
- ❑ Lower bowel gas several hours after eating
- ❑ Burning stomach sensations, eating relieves
- ❑ Coated tongue
- ❑ Pass large amounts of foul-smelling gas
- ❑ Indigestion 1/2-1 hour after eating; may be up to 3-4 hours
- ❑ Mucous colitis or irritable bowel
- ❑ Gas shortly after eating
- ❑ Stomach “bloating” after eating

7a

- ❑ Insomnia or awaken after few hours of sleep – difficult to go back to sleep
- ❑ Nervousness
- ❑ Can’t gain weight
- ❑ Intolerance to heat
- ❑ Highly emotional
- ❑ Flush easily
- ❑ Night sweats
- ❑ Thin, moist skin
- ❑ Inward trembling
- ❑ Heart palpitates
- ❑ Increased appetite without weight gain
- ❑ Fast pulse at rest
- ❑ Eyelids and face twitch
- ❑ Irritable and restless
- ❑ Can’t work under pressure

7b

- ❑ Increase in weight
- ❑ Decrease in appetite
- ❑ Fatigue easily
- ❑ Ringing in ears
- ❑ Sleepy during day
- ❑ Sensitive to cold
- ❑ Dry or scaly skin
- ❑ Constipation
- ❑ Mental sluggishness
- ❑ Hair coarse, falls out
- ❑ Headaches upon arising, wear off during day
- ❑ Slow pulse, below 65
- ❑ Frequency of urination
- ❑ Impaired hearing
- ❑ Reduced initiative

7c

- ❑ Failing memory
- ❑ Low blood pressure
- ❑ Headaches, “splitting or rending” type
- ❑ Decreased sugar tolerance

7d (+2- female cycle)

- ❑ Abnormal thirst
- ❑ Bloating of abdomen
- ❑ Weight gain around hips or waist
- ❑ Sex drive reduced or lacking
- ❑ Tendency to ulcers, colitis
- ❑ Increased sugar tolerance

7e

- ❑ Dizziness
- ❑ Headaches
- ❑ Hot flashes
- ❑ Increased blood pressure
- ❑ Hair growth on face or body (female)
- ❑ Sugar in urine (not diabetes)
- ❑ Masculine tendencies (female)

7f

- ❑ Weakness, dizziness
- ❑ Chronic fatigue
- ❑ Low blood pressure
- ❑ Nails weak, ridged
- ❑ Tendency to hives
- ❑ Arthritic tendencies
- ❑ Perspiration increased
- ❑ Bowel disorders
- ❑ Poor circulation
- ❑ Swollen ankles
- ❑ Crave salt
- ❑ Brown spots or bronzing of skin
- ❑ Allergies - tendency to asthma
- ❑ Weakness after colds, influenza
- ❑ Exhaustion - muscular and nervous
- ❑ Loss of strength or endurance
- ❑ Muscle weakness
- ❑ Respiratory disorders

81

- ❑ Drowsiness after eating
- ❑ Muscular soreness
- ❑ Rapid heartbeat
- ❑ Hyper-irritable
- ❑ Feeling of a band around your head
- ❑ Melancholia (feeling of sadness)
- ❑ Swelling of ankles
- ❑ Diminished urination
- ❑ Tendency to consume sweets or carbohydrates
- ❑ Muscle spasms
- ❑ Blurred vision
- ❑ Loss of muscular control
- ❑ Numbness
- ❑ Night sweats
- ❑ Rapid digestion
- ❑ Sensitivity to noise
- ❑ Redness of palms of hands and bottom of feet
- ❑ Visible veins on chest and abdomen
- ❑ Hemorrhoids

82

- ❑ Apprehension (feeling that something bad will happen
- ❑ Nervousness causing loss of appetite
- ❑ Nervousness with indigestion
- ❑ Gastritis
- ❑ Forgetfulness
- ❑ Thinning hair
- ❑ Very easily fatigued
- ❑ Depression of long standing
- ❑ Night urination frequent
- ❑ Depression
- ❑ Pain on inside of legs or heels
- ❑ Feeling of incomplete bowel evacuation
- ❑ Lack of energy
- ❑ Migrating aches and pains
- ❑ Tire too easily
- ❑ Avoids activity
- ❑ Leg nervousness at night
- ❑ Diminished sex drive

WOMEN ONLY:

- ❑ Premenstrual tension
- ❑ Painful menses
- ❑ Depressed feelings before menstruation
- ❑ Menstruation excessive and prolonged
- ❑ Painful breasts
- ❑ Menstruate too frequently
- ❑ Vaginal discharge
- ❑ Hysterectomy / ovaries removed (circle: yes / no)
- ❑ Menopausal hot flashes
- ❑ Menses scanty or missed
- ❑ Women: menstrual disorders
- ❑ Young girls: lack of menstrual function
- ❑ Acne, worse at menses
- ❑ Other:

MEN ONLY:

- ❑ Prostate trouble
- ❑ Urination difficult or dribbling
- ❑ Lack of stamina
- ❑ Other:

Section C

More of getting to know you and being able to holistically facilitate true change consists of gaining a clear perception on your constitutional state. The questions below target the condition of your metabolic cycle and pin point your Ayurvedic Dosha/type.

Describe yourself in each of the following categories:

Mentally (i.e. sharp, efficient, slow, spacy, etc.):

_____

Emotionally (i.e. enthusiastic , inhibited, creative, open, held back, emotional etc.):

_____

Physical (i.e. slow, heavy (feeling or literally overweight), fit, athletic, lethargic, etc.):

_____

What category would you describe yourself as in general A, B, or C? Place a star by the category in which you relate to the most. Underline the words in any category that you resonate with:

Category A: I experience dryness of skin, especially in winter months. My hands and feet are typically cold. I often have difficulty falling asleep or staying asleep. I walk purposely, outgoing and like to keep active. My energy fluctuate or comes in bursts. I can have a restless mind, but imaginative. My

communication is precise, convincing, or direct. Memorization is not my strength, I learn best by listening. By nature I am anxious or worrisome. I can be careless with spending and impulsive.

Category B: I sweat easily, often feel hot, appetite is good and I can eat a lot but spicy foods can cause upset. I don't tolerate skipping meals well. I tend to be meticulous and be a perfectionist. I can become irritable or angry quite easily but don't hold grudges. I am usually critical of myself and others. I'm am strong willed, others perceive me as stubborn. I like to splurge on luxuries on occasion. I consider myself to be efficient. I don't tolerate hot weather well. My health aliments consist of tendencies towards skin conditions, ulcers, and other inflammatory conditions.

Category C: Have a relatively steady energy level, good endurance, and strong stamina. Tend to be slow, methodical, and relaxed, constant appetite, and can skip meals easily. I am a sound sleeper, would love to sleep in, and a slow starter in the mornings. I tend to be reluctant to take on new responsibilities/commitments. I tend to be more frugal and conservative. I am rather susceptible towards congestion/mucus and sinus problems.

Section D

Reflect on the following discussion Questions. Highlight or circle what applies to you:

Check Family Members that Apply	yes/often	Somewhat or at times	No/not at all	In the past, but no longer applies
Do you feel you have direction, intention, and are able to move forward in life productively and positively?				
Is there anything you feel out of control of that is holding you back from accomplishing your goals?				
Is financial security or personal gain maybe a bit more important to you than it should be?				
Do your emotions go from one extreme to another?				
Do you try to hide or control your feelings?				
Do you have a difficult living in the present moment and feel disconnected from reality at times?				
Are your sexual relationships mutual and respectful, and can you be totally comfortable with your partner?				
Are you told that you don't understand people and have a hard time stepping into another's shoes?				
Do you enjoy being creative, musical, or spending time for yourself?				
Do you find planning ahead, scheduling, or commitments difficult?				
Are you flexible and spontaneous too much?				
Are you afraid to be alone, or have any fears or phobias?				
Do you have difficulties making decisions? Do thoughts of what others may think enter into your thought processes more than they should?				
Do you tend to take on too much, have a hard time letting others down, or prefer to do things yourself?				
Do negative memories tend to linger more than you think they should or want them to? Do you have a tendency to hold grudges?				

Do you feel stifled (feel a lack of freedom in your life)?				
Do you have a fear of being rejected, hurt, or let down?				
Do you find yourself in situations giving more than you think you should have or being taken advantage of (lack to set boundaries at times)?				
Do you find yourself to be envious or wish to have nice possessions?				
Do you trust without reservation?				
Do you have good organization and planning skills?				
Are you able to free yourself of old family values, beliefs and commitments/traditions if you realize those things have become un-healthy?				
Are you confident in verbalizing your thoughts and generally feel valued				
Are you concerned with financial security, and spend too much time worrying about it?				
Are you shy and have difficulty communicating yourself or are you too talkative (nervous talk)?				
Do you trust your intuition and insights?				
Do you consider yourself to be perceptive or intuitive?				
Can you release your fears and anxieties so as not to hang on to negative thoughts?				
Are you able to balance your imagination and fantasy realm with reality				
Do you tend to feel lonely or are you often depressed?				
Are you unable to give yourself credit?				
Do you feel the spiritual force and are able to call upon it?				
Do you lack faith because you prefer to believe in your own abilities?				
Do you trust in the divine and feel a peace about your spiritual security?				

PAIN – PRACTITIONER USE

Pain Symptoms (In Order of Severity) :

a._____ Began (Mo/Yr) _____ Previous Episodes (Mo/Yr)_____
b._____ Began (Mo/Yr) _____ Previous Episodes (Mo/Yr)_____
c._____ Began (Mo/Yr) _____ Previous Episodes (Mo/Yr)_____

Please circle areas of pain or discomfort and mark them using the codes listed below:
N=Numbness, T=Tingling, B=Burning, P=Pain, S=Soreness, A=Ache, SB=Stabbing, SF=Stiffness, X=Scars

MARK: Frequency and Severity:

1=Annoying (20% of the time)
2=Impairment to Activity (40%)
3=Need Medication (60%)
4=Impairment with Medication (80%)
5=Severe (Need Hospitalization) (100%)

	Location	Frequency	Severity	Initial Cause	Getting Worse? Y/N
a.	_____	_____	_____	_____	Yes
b.	_____	_____	_____	_____	Yes
c.	_____	_____	_____	_____	Yes

Does it affect other areas of body? If so, explain:
_____