*(PLEASE PRINT NEATLY IN BLACK or Blue INK)*

**Appointment: Date \_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_AM / PM**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | |  |
| Address: |  | |  |
| City, State, Zip |  | |  |
| E-mail: |  | |  |
| Phone #: | Birthdate: | | Age: |
| Marital Status: | No. of children: | | Age(s): |
| Occupation: |  | |  |
| What would you like to receive from your Ayurvedic Consultation? | |  | |
|  |  | |  |
|  |  | |  |
|  |  | |  |

# Financial Policy Agreement

1. Fees
   1. 2Hr Initial Consultation: $290 EA with report of findings; OR
   2. 1Hr Initial Consultation: $100 EA (no report of findings).

NOTE: Fees are charged for all missed appointments, ***without 24 hours notice***.

1. Additional fees apply for follow up visits, herbal formula design, preparation and shipping.
2. I have read and understand the financial policies.

**Patient’s Signature**: **Date**:

Office Use Only

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Informed Consent**

Ayurveda is a natural healing system that has been successfully practiced for thousands of years. Originating in ancient India, this medical tradition states that each person’s path toward optimal health is unique--because each person is unique. The healing programs I offer are based on effective, time-honored principles that focus on understanding your particular body-mind constitution and the unique nature of your imbalance.

Your program may include lifestyle adjustments, dietary changes, herbs, color therapy, sound therapy, aromatherapy, massage therapy, and other natural therapeutics. In order to successfully implement these Ayurvedic principles into your life, frequent regular follow-up visits are recommended over a six to twelve month period.

My goal is to create within your body and mind an optimum environment for healing to take place and to maximize your body's ability to heal itself.

If you are suffering from a disease or symptom that has not been evaluated by a Medical Doctor or another licensed health care professional, I recommend that you receive a proper evaluation and may provide you with a referral form. If I refer you to a Medical Doctor, you will be required to go or sign an acknowledgment that one was recommended to you.

While I may take your blood pressure and vital signs, and perform some examination techniques similar to a routine medical examination, I am evaluating the findings from an Ayurvedic perspective only and not from a Western medical perspective. **This examination does not take the place of a medical evaluation.**

I have read and understand the above information and give my permission to begin a program of Ayurvedic health care with Carla Levy, C.A.S.

**Patient’s Signature: Date:**

**Confidential Patient History**

# (1) Past Medical History (Include major conditions and dates of treatment and procedures performed)

|  |
| --- |
| Serious illnesses: |
| Hospitalizations and/or Operations: |
| List other pertinent past conditions: |
| Have you been under the care of a licensed health care professional in the past year: |
| ❑ Yes ❑ No If Yes, for what reasons: |

# (2) Food Choices (What types of food do you eat regularly and at what time?)

|  |
| --- |
| Breakfast: |
| Lunch: |
| Dinner: |
| Snacks: |
| Cravings: |

# (3) Daily Liquid Intake (Enter number of 8 ounce cups per day)

❑ Plain water \_\_\_\_\_\_\_ ❑ Caffeinated Coffee/ Tea \_\_\_\_\_\_\_ ❑ Alcohol \_\_\_\_\_\_\_ ❑ Other \_\_\_\_\_\_\_

(4) Habitual Eating Patterns

Describe any current or past eating patterns or any other food related issues

|  |
| --- |
|  |

(5) Allergies or Sensitivities: *(Describe allergic reactions to substances including food, pollens, and medicines?)* Please list medicines.

|  |
| --- |
|  |

(6) Regular Activities *(Indicate frequency of occurance of the following)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Exercise: | **❑** None | **❑** Occasionally | **❑** Monthly | **❑** Weekly | **❑** Daily |
| Yoga: | ❑ None | ❑ Occasionally | ❑ Monthly | ❑ Weekly | ❑ Daily |
| Meditation: | **❑** None | **❑** Occasionally | **❑** Monthly | **❑** Weekly | **❑** Daily |

(7) Sexual Activity

A person’s level of sexual activity impacts health and well-being in the same way as other aspects of daily life such as diet or sleep. Is your current sexual activity satisfactory?

❑ Yes ❑ No

**Applicable Symptoms, please check all that apply:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Digestion/ Elimination | ☐ | Constipation (less than 1 bowel movement/ day) | | | | ☐ | Diarrhea | | | | | ☐ | Slow and easy elimination | | | |
|  | ☐ | Gas | | | | ☐ | Alt. constipation/ diarrhea | | | | | ☐ | Nausea or vomiting | | | |
|  | ☐ | Dry/ hard stool | | | | ☐ | Burning or loose stools | | | | | ☐ | Mucus in stools | | | |
|  | ☐ | Excessive belching | | | | ☐ | Acid indigestion | | | | | ☐ | Heaviness after eating | | | |
|  | ☐ | Bloated after eating | | | | ☐ | Blood in stools | | | | | ☐ | Sleepy after eating | | | |
|  | ☐ | Abdominal pain | | | | ☐ | Rectal pain/ hemorrhoids | | | | |  |  | | | |
|  |  |  | | | |  |  | | | | |  |  | | | |
| Appetite | ☐ | Variable appetite | | | | ☐ | Strong appetite | | | | | ☐ | Dull appetite | | | |
|  | ☐ | Forget to eat | | | | ☐ | Excessive hunger | | | | | ☐ | Emotional eating | | | |
|  | ☐ | Light headed or anxious if I do not eat | | | | ☐ | Irritable or angry if I do not eat | | | | | ☐ | If I do not eat, it really does not bother me | | | |
|  |  |  | | | |  |  | | | | |  |  | | | |
| Weight | ☐ | Do not gain weight easily | | | | ☐ | Stable weight | | | | | ☐ | Gain weight easily and lose it slowly | | | |
|  |  |  | | | | ☐ | If I gain weight, easy to lose | | | | |  |  | | | |
|  |  |  | | | |  |  | | | | |  |  | | | |
| Temperature | ☐ | Feel cold most of the time | | | | ☐ | Feel warm most of the time | | | | | ☐ | Usually comfortable but tend to feel cool | | | |
|  | ☐ | Cold hands and/ or feet | | | | ☐ | Feel hot most of the time | | | | |  |  | | | |
|  |  |  | | | |  |  | | | | |  |  | | | |
| Skin | ☐ | Dry skin | | | | ☐ | Yellow of reddish skin | | | | | ☐ | Oily skin | | | |
|  | ☐ | Cracked skin | | | | ☐ | Rashes | | | | | ☐ | Clammy skin | | | |
|  | ☐ | Rough skin | | | | ☐ | Itchy skin | | | | |  |  | | | |
|  |  |  | | | |  |  | | | | |  |  | | | |
| Sleep | ☐ | Insomnia | | | | ☐ | Interrupted sleep | | | | | ☐ | Deep sleep | | | |
|  | ☐ | Restless sleep | | | | ☐ | Need darkness to sleep | | | | | ☐ | Hard to wake | | | |
|  |  |  | | | |  |  | | | | | ☐ | Excessive sleep | | | |
|  |  |  | | | |  |  | | | | |  |  | | | |
| Bones/ Joints | ☐ | Cracking or popping | | | | ☐ | Inflamed joints | | | | | ☐ | Swollen joints | | | |
|  | ☐ | Osteopenia or osteoporosis | | | | ☐ | Hot joints | | | | | ☐ | Bone spurs | | | |
|  | ☐ | Painful joints | | | |  |  | | | | |  |  | | | |
|  |  |  | | | |  |  | | | | |  |  | | | |
| Sweat | ☐ | Little or no sweat | | | | ☐ | Excess sweat | | | | | ☐ | Cold/ clammy | | | |
|  |  |  | | | | ☐ | Smelly sweat | | | | |  |  | | | |
|  |  |  | | | |  |  | | | | |  |  | | | |
| Mental/ emotional | ☐ | Spacey | | | | ☐ | Self destructive | | | | | ☐ | Lethargic | | | |
|  | ☐ | Worry/ anxiety | | | | ☐ | Irritable and angry | | | | | ☐ | Melancholy | | | |
|  | ☐ | Overwhelmed | | | | ☐ | Resentful | | | | | ☐ | Depression | | | |
|  | ☐ | Forgetful | | | | ☐ | Critical/ judgmental | | | | | ☐ | Stubbornness | | | |
|  |  |  | | | |  |  | | | | |  |  | | | |
| Menses | ☐ | Irregular | | | | ☐ | Regular | | | | | ☐ | Heavy flow | | | |
|  | ☐ | Light flow | | | | ☐ | Medium flow | | | | |  |  | | | |
|  | ☐ | Cramping pain during menses | | | | ☐ | Discomfort | | | | |  |  | | | |
|  |  |  | | | |  |  | | | | |  |  | | | |
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| **Current Medications, Herbs, or Supplements**  What medications, herbs, and/ or supplements are you taking? (Please include significant remedies that you have stopped taking, including birth control and hormone replacement therapies. | | | What have the benefits been? |  |  |  | | |  |  |  |  | |  |  |  |
| What dosage? |  |  |  | | |  |  |  |  | |  |  |  |
| For how long? |  |  |  | | |  |  |  |  | |  |  |  |
| For what purpose? |  |  |  | | |  |  |  |  | |  |  |  |
| Prescribed by?  (Self, MD, other?) |  |  |  | | |  |  |  |  | |  |  |  |
| Herb? Drug?  Vitamin? |  |  |  | | |  |  |  |  | |  |  |  |
| Over-the-counter? (OTC)  Prescription? (Rx) |  |  |  | | |  |  |  |  | |  |  |  |
| **Substance** |  |  |  | | |  |  |  |  | |  |  |  |