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Confidential Client History

Section A: Client Information

Client's Name:		
Client's Address:		
City, State, Zip:		
Home Phone:	Work:	Cell:
Email:	Date of Birth:	Age:
Marital/partner status:	# of children:	Ages:
Who do you live with? How is the home environment for you?		
Occupation:	Number hours/week:	
Does your job give you satisfaction and/or stress and why?		
Practitioner Notes:		

Section B: Financial Policy Agreement

1.There is a $225.00 charge for your initial visit and report of findings. Payment is due before or at the initial consultation. Additional follow-up visits are $ 85.00 each, or you may buy packages of two or more follow up visits at a time for $80.00 each. Herbal formulas, if recommended, are at additional cost. 2. If you miss an appointment without giving 24 hours notice, you are responsible for half the fee.

I have read and understood the financial policies of Joyful Journey Ayurveda.

Client Signature:	Date:

Section C: Past Medical History

Include dates of treatment and procedures performed

What serious illnesses or injuries have you had?
What operations and prior hospitalizations have you had?
List other pertinent past conditions including conditions such as skin issues, fibromyalgia, etc.

For Women Only:
Are you menopausal? ☐ Y ☐ N Date of last period ______________________
If you have children, list any challenges with your pregnancy, labor and postpartum periods.

List any *past* issues with your reproductive system including PMS symptoms, endometriosis, fibroids, miscarriages, abnormal pap smears, infertility:

Section D: Family History

Disease	**Detail (if applicable)**	**Relative**	**Practitioner Notes Only:**
Cancer			
Stroke			
Diabetes			
Heart Disease			
Mental Disorder			
Other (explain)			

Section E: Current History

What are your goals and intentions in receiving an Ayurvedic consultation?

What are your current health concerns at this time and when did they begin? (if you need more room you can use an extra blank sheet)

Are you currently under the care of a Medical Doctor or Health Care Professional? If so, for what?

Is there a possibility that you are pregnant? (circle) YES / NO

If yes, how your pregnancy is going?	
Current Diagnosed Conditions (use additional paper if needed)	Related Medications/Treatment (medications detail in next section)

Section F: Current Medications, Herbs, and Supplements

Please list any medications, herbs, and supplements that you are currently taking as well as any significant remedies that you have recently stopped taking. Add additional medications on a separate page.

Name of Substance	Prescription, OTC, Herb, Vitamin, etc.	Prescribed by, when started:	Purpose:	Dosage:	What effects have you noticed?

Section G: Daily Routines

Do you subscribe to any particular diet? (vegetarian, vegan, macrobiotic, other) Do you eat meat, chicken, fish, egg, dairy, or soy? How many servings per week of white sugar____ white bread/pasta____ crackers/chips/pretzels_____
Do you have any allergic reactions to substances or foods?
Describe any current or past problems with chronic eating disorders or other food related issues?
Do you drink coffee, tea, soda, or juice? How many cups of each? How many servings of processed sugar desserts per week?
How much water do you drink per day?
If you drink alcohol, how many glasses per week and what types of alcohol?
Do you have any routines surrounding eating? (what does your mealtime look like - do you eat while working, on the go, while reading, watching tv or another activity; do you say blessings or grace before a meal, do you eat alone or with others, etc?)

How often do you eat out? Where/What types of food?
In cooking, what do you use primarily (can put 1, 2, 3 in ranking use) …. Fresh, frozen, canned, organic foods? What types of spices and condiments primarily?
How is your food prepared (by another family member, out in restaurants, stove top/oven, microwave, pressure cooker, grill)?
What types personal care products do you use (soap, shampoo, cosmetics, skin care)?
Do you have regular spiritual practices and how often do you do them? (meditation, yoga, journaling, spiritual reading, gratitude practice, religious practice such Bible study or going to church)
Do you exercise regularly? ☐ yes ☐ no Type of exercise & length of time:
Describe any creative activities or hobbies:
If you smoke, how many packs of cigarettes per day?

If you smoked in the past, how much did you smoke?		When quit?
Are you a past or current user of recreational drugs?		
Substance:	Amount:	When quit:
Substance:	Amount:	When quit:
How is your libido/sexual energy?		
How many hours of sleep are you getting per night?		
Do you feel well-rested with enough energy to get through your day? If not, why?		
What feels stressful or ineffective about your daily habits that you would like to work on changing?		

Section G: Routine Details

MORNING (wake up, personal care routine, eating, beverages, exercise, work, activities, commute)

5:00

6:00

7:00

8:00

9:00

10:00

11:00

MID DAY (typical meals, snacks, breaks during the day, activities, beverages, leaving work)

12:00

1:00

2:00

3:00

4:00

5:00

EVENING (typical meals, eating out, activities, late night eating, computer use, bedtime)

6:00

7:00

8:00

9:00

10:00

past 11:00

Section H: System Symptoms

For the following section: Please check symptoms that you are **CURRENTLY** experiencing with the following details:

- ***Frequency*** *- number of times per day, week or month (1W, D, 3M, ongoing etc)*
- ***Intensity*** *using a range with "1" being the most mild, '4' what is regular and strong enough to seek support and '10' shutting you down in some way*
- ***Onset*** *- when the symptom started (2 months ago, 5 years ago, age 20, etc)*
- ***Duration*** *- how long the symptom lasts (constant, 20 minutes, 2 hours)*
- *Put Y(es) or N(o) for* ***evaluated by a Licensed Health Care Practitioner*** *(LHCP) which means having a conversation with the appropriate health provider who has scope of practice with such symptoms.*

I-1 Mind/Emotions

Current 'X'	Symptom	Frequency	Intensity 1 - 10	Onset	Duration	Evaluated LHCP?	Tracking Y/N	VPK
	Worry							
	Anxiety/Fear							
	Overwhelm							
	Spaciness							
	Self Critical/Self Sabotaging Thoughts							
	Difficulty Remembering							
	Difficulty Focusing							
	Anger/Rage							
	Resentment							
	Jealousy/Envy							
	Being Critical of Others							
	Mental Lethargy/Slow Thinking							
	Sadness							
	Depression							
	Insomnia/disrupted sleep							
	Fatigue							
					Vikrti Total: V:	**P:**	**K:**	

Intern Notes:

Current 'X'	Symptom	Frequency	Intensity 1 - 10	Onset	Duration	Evaluated LHCP?	Tracking Y/N	VPK
	I-2 Digestion/Elimination							
	Burning Indigestion/ Heartburn							
	Belching							
	Nausea							
	Excessive Gas (often)							
	Stomach Gurgling							
	Heaviness after Eating							
	Bloating after Eating (gas that can't escape)							
	Colicky Pain							
	Hemorrhoids							
	Constipation (<1 BM/day)							
	Diarrhea/Loose Stools							
	Constipation/Diarrhea							
	Heat with Elimination							
	Bloody Stool							
	Anal Itching							
	Irregular Appetite							
	Intense Hunger							
	Little/Low Appetite							

Vikrti Total: V: P: K:

Intern Notes:

Current 'X'	Symptom	Frequency	Intensity 1 - 10	Onset	Duration	Evaluated LHCP?	Tracking Y/N	VPK
I-3 Head								
	Headaches							
	Dizziness							
	Fainting Spells							
	Loss of Balance							
	Thinning/Loss of Hair							
I-4 Ears & Nose								
	Hearing Loss							
	Ringing in the Ears							
	Earaches							
	Loss of Smell							
	Nose Bleeding/Dryness							
	Nose Discharge/ Post-Nasal Drip							
	Sinus Congestion							
I-5 Eyes								
	Painful/Sore Eyes							
	Red Eyes							
	Burning Eyes							
	Mucous in the Eyes							
	Puffy Eyes							
	Dry Eyes							
	Itchy Eyes							
	Eye Tics/Twitching							
	Blurred/Loss of Vision/Cataracts							
					Vikrti Total: V:	**P:**	**K:**	

Intern Notes:

Current 'X'	Symptom	Frequency	Intensity 1 - 10	Onset	Duration	Evaluated LHCP?	Tracking Y/N	VPK
I-6 Mouth								
	Excessive Thirst							
	Bad Breath							
	Lip Ulcers/Lesions							
	Dry/Cracking Lips							
	Bleeding/ Receding Gums/ Sensitive Gums							
	Dry Mouth							
	Tooth Pain/ TMJ							
I-7 Neck								
	Pain/Stiffness							
	Swollen Glands							
I-8 Chest								
	Chest Pain							
	Tightness/Pressure							
	Heart Palpitations							
	Shortness of Breath							
	Painful/Difficult Breathing							
	Persistent Cough							
	Frequent Chest Colds							
I-9 Skin								
	Dry/Flaky Skin							
	Rashes							
	Acne							
	Changing/Bleeding Moles							
	Fungus/Eczema/Psoriasis							
	Strong Smelling Perspiration							
					Vikrti Total: V:	**P:**	**K:**	

Intern Notes:

Current 'X'	Symptom	Frequency	Intensity 1 - 10	Onset	Duration	Evaluated LHCP?	Tracking Y/N	VPK
	I-10 Urinary							
	Painful Urination							
	Heat with Urination							
	Urine Retention/Dribbling							
	Frequent Urination							
	Blood in Urine							
	Kidney/Bladder Infections							
	I-11 Muscles & Joints							
	Swelling in Joints							
	Pain/Ache/Stiff in Joints							
	Muscle/Bone Pain							
	Muscle Weakness/Atrophy							
	I-12 Nerves							
	Loss of Sensation							
	Tingling Sensation							
	Tremors in Limbs							
	Uncoordinated Muscles							
	I-13 Circulation							
	Varicose Veins							
	Cold Hands/Feet							
	Swollen Ankles/ Calf Pain							
	Overall Feeling Cold/Warm							
	Mild Puffiness/Water Retention in Body							
					Vikrti Total: V:	**P:**	**K:**	

Intern Notes:

Current 'X'	Symptom	Frequency	Intensity 1 - 10	Onset	Duration	Evaluated LHCP?	Tracking Y/N	VPK
I-14 Male System								
	Swollen/Painful Prostate							
	Low Sperm Count							
	Low Sperm Motility							
	Genital Sores/Lesions							
	Genital Discharge							
	Erection Difficulty							
	Genital Sores/STD							
I-15 Female System								
	Irregular Cycle							
	Heavy/Prolonged Bleeding							
	Missed Menses							
	Painful Menses/Cramps							
	Spotting/ Discharge							
	PMS Symptoms ☐bloating ☐headaches ☐weight gain ☐irritable ☐breast tenderness ☐weepy							
	History of Miscarriage/Infertility							
	Genital Sores/STD							
	Ovarian Cyst/ Fibroids							
	Hot Flashes							
	Vaginal Itching							
					Vikrti Total: V:	**P:**	**K:**	

Intern Notes:

I-16 OTHER								
	Sudden weight loss							
	Sudden weight gain							
Any other symptom you're experiencing not previously covered above								

Vikrti Total: V: P: K:

Intern Notes: