Health Quest Institute
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Ayurvedic Consultation Intake Form

CONTACT INFORMATION:

Name: _____ Date: _____ Home Address: _____ City: _____ State/Region: _____ Postal Code/Zip:_____ Mobile Phone: _____ Home Phone: _____ Email: _____

PERSONAL INFORMATION:

DOB: (MM/DD/YYYY) _____ Time of Birth (include AM/PM): _____

Place of Birth: City: _____ State/Region: _____ Country:_____ Age: _____ Gender: _____ Occupation:_____ Marital Status: _____ Children & Ages: _____ Referred by: _____ Family Physician: _____ Primary Care Provider Name & Title: _____ Phone: _____ Address: _____ City: _____ State: _____ Zip:_____

A) Are you currently under a physician's care for a specific medical problem? If yes, for what and for how long?

_____

_____

_____

CONCERNS: Please tell us your present concerns and/or conditions. How long have they troubled you?

_____

_____

_____

B) What would you like to achieve or change in terms of your health and wellness?

_____

_____

_____ History of Smoking: (what, how often, how much, how many years) _____ Drinking Alcohol: (what, how often, how much, how many years) _____

Recreational/Non-prescription Drugs: (what, how often, how much, how many years) _____

What surgeries have you had? (Include dates) _____ Last physical examination: Date: _____ Blood Pressure: _____ Cholesterol: _____ Height: _____ Weight: _____ Weight Changes? _____

What known allergies do you have? _____ *The*

What prescription drugs or medications are you currently taking or have taken within the last 6 months?

Prescription:	**Reason**	**Duration taken**	**Current dosage**	**Quantity per**	**Frequency per day**	**Before/after/during or between meals**

Herbal/ vitamin supplements	**Reason**	**Duration taken**	**Current dosage**	**Quantity per**	**Frequency per day**	**Before/after/during or between meals**

Attach additional sheet(s) if necessary

OBJECTIVES:

Please check the items that reflect your main objectives:

1. I would like an alternative approach to allopathic medicine for managing illness and disease.

2. I would like to improve my general health and wellness and reduce my vulnerability to illness and disease. 3. I would like to improve my lifestyle and dietary practices to improve my health.

4. I would like to change my habits and behavioral patterns to improve my relationships with others.

5. I would like to manage stress, tension, and worry to attain a more stable emotional nature.

How would your life be different if you were to achieve these objectives to your satisfaction?

_____

_____

_____

C) <u>PERSONAL HISTORY</u>: Do you or your family members have a history of the following? (Please check boxes all that apply)

	Myself	***Maternal***	***Paternal***		**Myself**	***Maternal***	***Paternal***
Allergies to Food				Stroke			
Allergies to Drugs				Cerebrovascular Accident			
Dental Treatment Complications				Cancer			
Bleeding Gums				Chemotherapy			
Contact Lenses				Radiation Treatment			
Glaucoma				Hepatitis A			
Eye Surgery				Hepatitis B			
Pain in the Ear				Hepatitis Non-A / Non-B			
Ringing in the Ear				Mononucleosis			
Shortness of Breath				Jaundice			
Asthma				Anemia			
Pneumonia				Gallstone			
TB				Kidney Disease			
High Blood Pressure				Kidney Stones			
Low Blood Pressure				Bladder Disease			
Dizziness				Thyroid Condition			
Fainting				Thyroid Medication			
Seizures				Ulcers			
Convulsions				Intestinal Bleeding			
Epilepsy				Chronic Constipation			

Diabetes				Recurring Diarrhea			
Feet or Ankles Swelling				Arthritis			
Chest Pain				Implant			
Angina				Prosthesis			
Heart Murmur				Prolonged Bleeding If Cut			
Heart Attack				Psychiatric Treatment			
Heart Disease				Venereal Diseases (STDs)			
Heart Surgery				HIV Exposure			
Rheumatic Fever				Sleep Disorders			

Any other family illnesses not listed ? _____ *The*

History of Any Other Disease or Problems? Please list any other personal illnesses, surgeries, diseases, injuries, trauma, emotional stresses, mental stresses, life-style conditions, addictions, alcohol, drug abuse, changes of weight, known allergies, or anything else to help us clearly understand your health condition:

_____

_____

_____ **EXERCISE:**

Do you currently engage in any exercise or physical activity? If so, what type(s)?

_____

_____

_____

Have you ever done Yoga postures before? If so, what type(s), how often?

_____

_____

_____

*__FEMALES ONLY:__ Age of onset of menses:_____ Are you currently pregnant? _____ Number of Weeks _____

Number of previous pregnancies:_____ Difficult past pregnancies? _____

Complications: _____

Do you use Birth Control? Yes No If so, what type(s)? _____ How long? _____ Date of Last Menstrual Period: _____ Length of cycle:_____ Days between cycles: _____ Cycles: Regular Irregular Color of Blood:_____ Flow: Heavy Medium Light Clots: Yes No When? _____ Pain and/or difficulty during cycle? _____ PMS symptoms: _____ Any other symptoms during cycle: _____ Yeast infections? _____ Urinary tract infection (UTI) (frequency, duration): _____ Menopausal stage / symptoms: _____

Other information: _____

***MALES ONLY:** Prostate Condition? _____ Other information: _____

Check All That Apply To You Currently And Within The Last Six (6) Months:

Category:			
Digestion	Irregular with	Quick digestion with	Slow digestion with
	Bloating	Acid Indigestion	Feeling of heaviness
	Gas/Flatulence	Heartburn	Lethargy
	Abdominal Discomfort	Burning pain	Sleepy after eating
	Gurgling Intestines	Still hungry after eating	Low energy after meals
	Breathlessness	Nausea	Excess mucous secretions
		Vomiting	
Appetite	Irregular	Excess hunger	Emotional eating (No urge for food but still eats)
	Sometimes eats at midnight	Sharp hunger	Dull / No appetite
		Desire to eat large amounts	

	of food Strong unbearable appetite Feels hypoglycemic		
Cravings	Fried food Hot spicy food Meat or other protein	Sweets Cooling foods & drinks	Hot, sharp, dry & spicy food Wine or alcohol
Elimination	Tendency toward constipation Dry Irregular Defecates without satisfaction Passes gas during elimination	Loose stools Diarrhea	Mucous in stool
Pain	Shifting Tearing Moving Vague Throbbing Colicky Cutting Excruciating with breathlessness, fear and tachycardia	Burning Sharp Hot Migraine headaches Sucking pain with fever, nausea and irritability Intense pain	Dull Stable Deep dull aching pain Can sleep through the pain
Skin	Dry Cracked Rough Thin Discolored Patchy	Hives Rash Urticaria Acne Tender Warm/hot to touch	Excess oily Thick Pallor Cold/clammy Lustrous

			Itchy Redness Boils Ruddy
Sweating	Scanty or no sweat	Cold/clammy	Excess Profuse with body odor

Category:			
Sleep	Insomnia Need night light Restless Difficulty falling asleep	Interrupted sleep Must have complete darkness Needs to read/TV to sleep	Excess sleep Daytime napping Heavy sleeper Slow to awaken Hypersomnia
Seasonal Allergies	Breathlessness Wheezing Constricted Breathing	Rash Itching eyes Hives Irritation Inflammation	Runny nose Watery eyes Congestion
Food Sensitivity	Night shades Leftovers Dry fruits Raw food	Hot spicy foods Sour foods Fermented foods	Dairy products
Muscle Reactivity	Twitching Cramping Weakness Numbness	Bruising Tenderness to touch Sore	Tumors Cysts Growths

	Tingling Spasms	Excess heat	Generalized weakness
Bone and Joints	Painful Popping Cracking Stiffness Loose Osteopenia Osteoporosis Medical fractures Scoliosis	Inflamed Hot / feverish Tender Inflammatory arthritis Osteomyelitis Bursitis	Swollen joints Bone tumors Bone spurs Osteosarcoma Non-inflammation with profuse infusion Sclerosis
Circulation	Cold extremities (hands, feet)	Burning hands / feet Bruises easily Tendency toward bleeding	Cold clammy hands Varicose veins Thrombotic element
Body weight	Variable Can't gain weight Thin or slender	Stable Tendency toward hyper metabolism	Tendency to easily gain weight Over-weight Obese Voluptuous Stout

Category:

General Symptomatology	Dry cough	Spontaneous bleeding	Cold
	Ringing ears	Hyper-sensitive to smells	Cough
	Light-headed	Hair loss	Congestion
	Dryness: external/internal	Excess thirst	Excess urination
	Hemorrhoid: External/ non- bleeding	Hemorrhoid: Internal/bleeding	Frequent urination
	Low back ache	Hot flashes	Fibrocystic
	Irregular metabolism	Tendency toward inflammatory conditions	Over salivation
	Dry mouth	Acidic saliva	Edema
	Receding gums	Hyper acidity	Slow metabolism
	Blackish brownish discoloration	Yellowish discoloration	Albuminuria
	Fatigue	Fainting	Lipoma(s)
	Lack of power, tone & strength	High metabolism	Cataracts
	Paralysis		
	Slipped disc		
	Hernia		
	Difficulty sweating		
	Cold extremities (hands, feet)		

Mental Emotional	Transient Depression Inability to concentrate Forgetful Worry Fear Anxiety Insecurity Loneliness Nervousness Grief Restlessness Repetitive thinking Spacey	Extreme depression with suicidal tendencies Anger Rage Resentful Judgmental Critical Envious Sharp tongued Vengeful Intolerant Irritable Aggressive Success-Failure mind set Seeks power, prestige and position	Prolonged depression Sloppy Slow Confused Greed Attachment Mental lethargy Resistant to change Laziness Unforgiving Stubborn Boredom
Nature of response within relationships	Talkative Uncertain Anxious Lonely Insecure Excitable Shy Spacey	Seeks power, prestige and position Perfectionist Competitive Seeker of knowledge	Based on acquiring comfort and pleasure

Other (Not Listed Above): _____