AcuReiki Healing Arts

INITIAL VISIT - CLIENT INTAKE SHEET - Ayurveda Lifestyle Counseling

NAME ____ DATE ______________________________
ADDRESS ____ PHONE #___________________________
Name of Emergency Contact ___________________________ PHONE#___________________________
EMAIL ADDRESS ____________________________________ DOB: _____________________________
Occupation: _______________________________________ Are you a fulltime student? Yes No

What are your current concerns? Please indicate your symptoms, their severity and duration. ______________
____
Are you currently under the care of a physician? YES NO

Medical History

Have you ever had an illness requiring hospitalization or surgery? YES NO
If yes, please describe the condition, the onset, duration, and resolution ________________________________
____
____

Have you ever had a serious injury (such as broken bones, severe strains, concussion, trauma)? If yes, please describe the type of injury, how long ago it occurred, and its resolution. ________________________________
____
____

Have you ever had mononucleosis, hepatitis or strep? If yes, when? ______________ Status? _____________
Have you ever been in any car accidents or other accidents? If yes, when? ______________________________
Please indicate injuries, if any, and their status or resolution ____
____
Have you had any pregnancies?_______ If yes, how many? _______ Complications? ____________________
Abortions? If yes, how many? ______ Any complications? ____

Are there any patterns of illness within your family? (i.e., such as heart problems, cancer, migraines)
If Yes, please describe: ____
and any long-term emotional conditions for your family: ____

CURRENT INFORMATION

Medications

Are you currently taking any prescription medications YES NO If yes, please provide information below.

Name of Medication	Reason for the Medication	Any side effects?

Are you currently taking any supplements, vitamins, herbs, homeopathic remedies, etc.? YES NO
(If yes, please list) ____
____
____
Have you taken recreational drugs recently? ____
Do you have a history of taking antibiotics? If Yes, when was the last time? __________________________
Have you ever taken birth control pills or hormonal therapy? _____________________________________

Are you currently ill or recovering from an illness? YES NO If yes, please indicate symptoms, onset, duration and current status. ____

____

Do you have any allergies or hayfever? If yes, please check the relevant symptoms:

_____ sneezing "fits"	_____ irritated bronchii, dry cough	_____ sore throat
_____ congested sinuses	_____ nonproductive "dry" pressure in sinuses	_____ itchy, irritated eyes
_____ skin rash	_____ wheezing, asthma	_____ itchy skin

Do you still have menstrual periods? YES NO If yes, are your cycles regular? ________________________
How many days in your cycle? ___________ If menses has stopped, when was your last period? _________
Do you have any pain or difficulties during your cycle?_______________________________________
If you are in perimenopause or menopause, are you experiencing any symptoms? ________________________

____

Systems of Elimination

Do you have any problems with urination? YES NO If yes, describe_________________________________
Color/frequency of urination: ____
Do you experience any of the following on a regular basis (please circle): constipation diarrhea
stomach irritation nausea bloating gas pain burning sensations

Do you have trouble sleeping? ______ If yes, how often does this occur? ______________________________
Do you have trouble falling sleep? ____ Do you go to sleep easily and then wake up too early? ____________
Both? _________ Once you wake up, are you able to go to sleep again? ___________________________
Do you wake up at the same time each night? ____

Do you feel warm or cool generally, physically? ____
Cold hands and/or feet? Heat in the palms of the hands and soles of the feet? ________________________

Nutrition/Digestion

Do you use artificial sweeteners, or consume foods and drinks that contain them? ____ Do you use MSG?____
Do you eat at fast food restaurants, Chinese restaurants, or use frozen/canned foods?
Do you cook with the microwave? ____
Are there any foods that you crave or feel "addicted" to? ____
Have you made any major changes to your diet recently? ____

Do you have difficulty with digestion? Such as ____ gas ____ bloating ____ burping _____ burning
____ heaviness in the stomach _____ stomach slow to empty

Do you have regular bowel movements each day? ____
Do you have any of the following problems, and if so, please indicate how often _________________________
Gas _____ Constipation?_____ Diarrhea ___________ Burning sensation upon elimination______

Are you happy with your current weight? _____ Do you feel (circle if appropriate) overweight underweight
Have you had fluctuations with your weight? If yes, by how much? _____________________________________

Have you tried extreme diets, such as fructarian, raw foods only, or long fasting sessions? _________________

____

Are you a vegetarian, vegan, or have other dietary restrictions? _____________________________________

____

Do you have known sensitivities or allergies to foods? ____
Are you allergic to latex? YES NO
(If you have an allergy to latex -- this crosses over into some foods as well, such as bananas, avocados, chestnuts, kiwi/ apple, carrot, celery, papaya, potato, tomato, melons, and others.)

Do you drink alcohol? If so, how often and how much? ____
Do you smoke? YES NO Do you drink coffee, black tea, or eat dark chocolate? ______________________

Do you consume cold/iced drinks or carbonated water or drinks? ______________________________________

Lifestyle
Do you watch TV? If yes, how many hours per evening (average) and what types of programs do you watch?
____

Do you exercise? If so, what do you do, and how often? ____
____

What type of physical activities do you do during the day (such as sitting at a computer, stand for long periods, lift heavy objects, etc.) ____

Looking at the lists below, please circle the conditions, issues, emotions, etc., that apply to you fairly often.

VATA	PITTA	KAPHA
dry eyes	red, irritated eyes	Bags (brown) under eyes
hearing loss	low back, neck pain (inflammation)	bronchitis
low back, neck pain (unstable vertebrae)	tension headaches	sinus headache
dizziness	itching/burning skin	subcutaneous cysts
receding gum / teeth problems	gingivitis	depression/lethargy
aversion to cold	aversion to heat	aversion to cold & damp
weak, stiff tendons	stiff tendons, knotted muscles	frequent colds
lax joints	arthritis	nausea after eating
fearful, anxious	shoulder/neck tension	accumulation of fat
indecisive	infections	mucous conditions
constipation	diarrhea	excessive sleeping
gas	PMS, cramps	water retention, edema
poor circulation	irritability, anger	

Is there anything else you want to mention? ____
____
____

<u>DISCLAIMER, WAIVER & RELEASE</u>

<u>Ayurveda Lifestyle Counseling</u>

Please be advised that:

- Information given in the Ayurveda Lifestyle Counseling session is for educational purposes, and that it is not a substitute for medical or psychological diagnosis and treatment.
- Ayurveda Lifestyle Counselors do not diagnose conditions nor do they prescribe, administer or recommend controlled substances and drugs that might be prescribed by a licensed practitioner.
- Ayurveda Lifestyle Counselors do not perform medical treatment or interfere with the treatment of a licensed medical professional. It is recommended that you see a licensed physician or licensed health care professional for any physical or psychological concerns. You have the right to choose to go to a licensed provider of healthcare.

It's important to note that Ayurveda Lifestyle Counselors are not licensed by the State of California or anywhere in the United States. Ayurveda has no state-recognized educational and training standards in the United States. They are not qualified to diagnose, prescribe, or treat any physical or mental illness unless they are licensed medical practitioners. Anything said in the course of the session is to educate you about Ayurvedic concepts, and that nothing said during session should be construed as medical advice.

Your Ayurveda Lifestyle Counseling session may include the following:

- Completion of a detailed client intake form, which consists of providing your contact and emergency information, medical history, and a description of your current concerns (if any).
- An introduction to the basic concepts of Ayurveda, including determining your *pakruti (default physical, emotional, mental characteristics as described using Ayurvedic principles),* explanation of the *doshas (Vata, Pitta, Kapha aspects),* and how the foods you consume, activities you do, and your various environments can influence them.
- An explanation of the energetics of herbs, and how different herbs recommended for the same health problem might be more or less effective because of their energetics interacting you're your *pakruti.* **I do not sell herbs or supplements**, and although I instruct you in various herbs that are generally used to balance Vata, Pitta, and Kapha, use of those herbs is completely up to your own discretion. <u>It is strongly recommended that you discuss any herbs with your licensed healthcare provider before purchasing or taking them.</u> This is especially important in terms of contraindications and possible drug interactions.
- Your initial appointment might be as long as 90 minutes. Follow-up appointments to check in are generally 30-60 minutes, and can be added to another type of session.

I, ____, have read the foregoing, understand it and agree to it.
(please print name)

CLIENT'S SIGNATURE ____ DATE _______________

SIGNATURE OF PARENT IF CLIENT IS UNDER THE AGE OF 18: _____________________________________