

**AYURVEDIC CONSULTATION INTAKE QUESTIONNAIRE**

In preparation for our work together, complete the questionnaire below. Please print the completed form and bring it with you to our first session.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Contact Information | | | | |
| Name: | | | Date: | |
| Phone: | | | | |
| Email: | | | | |
| Address: | | | | |
| Emergency Contact Person: | | | | |
| Relation: | | | | |
| Phone Number: | | | | |
|  |  |  |  |  |
| Personal Information | | | | |
| Date of Birth: | | Time of Birth: | | |
| Age: | | Height/Weight: | | |
| Place of birth: | | | | |
| The place of childhood: | | | | |
| Other places lived: | | | | |
| Place where symptoms started: | | | | |
| Chief concerns: | | | | |
|  |
| Origin, duration and progress of the symptoms of chief concerns: | | | | |  |
|  |
| Any recent changes or concerns in the following areas: | | | | |  |
| **Vāta** | **Pitta** | **Kapha** | **Āma** | **General** |  |
| ☐ dryness | ☐ diarrhea | ☐ congestion | ☐ coating on tongue | ☐ energy level |  |
| ☐ insomnia | ☐ loose stool | ☐ food or respiratory | ☐ low grade fever | ☐ throat/eyes/ears |  |
| ☐ gas | ☐ nausea | allergies | ☐ excess sleep | ☐ chest/lung/heart |  |
| ☐ bloating | ☐ migraines | ☐ edema | ☐ aches and pains | ☐ agni (appetite, |  |
| ☐ constipation | ☐ vomiting | ☐ heaviness | ☐ malaise | digestion) |  |
| ☐ hemorrhoids | ☐ skin rashes, acne, | ☐ dullness | ☐ lethargy | ☐ urine: clear, cloudy, |  |
| ☐ muscle twitching, | hives, boils | ☐ dull, vague pain | ☐ lack of energy | burning, difficult |  |
| cramping, numbness | ☐ bruising | ☐ cold, clammy hands | ☐ lack of appetite | ☐ nails |  |
| or weakness | ☐ excess thirst | ☐ difficulty sweating | ☐ sinking stool | ☐ menses |  |
| ☐ joint pain, cracking | ☐ burning, sharp pain | ☐ frequent urination |  | ☐ menopause |  |
| ☐ stiffness | ☐ spontaneous | ☐ excess oily skin |  | ☐ pregnancy |  |
| ☐ shifting, tearing pain | bleeding | ☐ excess sleep |  | ☐ other OB/GYN |  |
| ☐ dry cough | ☐ tenderness to touch | ☐ depression, greed, |  |  |  |
| ☐ cold extremities | ☐ excess body heat | attachment |  |  |  |
| ☐ dry skin | ☐ interrupted sleep | ☐ mental lethargy |  |  |  |
| ☐ restlessness | ☐ anger, rage, envy, |  |  |  |  |
| ☐ worry, fear, anxiety | judgement, critical |  |  |  |  |
|  |  |  |  |  |  |
| Health History | | | | |  |
| History of any serious illness: | | | | |  |
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| Family history, maternal: | | | | |  |
|  |
| Family history, paternal: | | | | |  |
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|  |  |  |  |  |  |
| Meals (Indicate time of day and food choice. Include all times if they vary through the week): | | | | |  |
| Breakfast: | | | | |  |
|  |
| Lunch: | | | | |  |
|  |
| Dinner: | | | | |  |
|  |
| Snacks: | | | | |  |
|  |
| Last food before bed: | | | | |  |
| Appetite: | | | | |  |
| Diet: ☐ Vegetarian ☐ Non-Vegetarian ☐ Other | | | | |  |
| Favorite foods: | | | | |  |
| Foods you crave/when you crave them: | | | | |  |
| Tastes you crave: ☐ Sweet ☐ Salty ☐ Sour ☐ Pungent ☐ Bitter ☐ Astringent | | | | |  |
| Least favorite foods: | | | | |  |
| Allergy triggers (food or materials): | | | | |  |
| Food sensitivities: | | | | |  |
| Specific digestive conditions: | | | | |  |
| Bloating/Gas? | | ☐ Yes ☐ No ☐ Sometimes | | |  |
| What time of day? | | |  |  |  |
| Acidity/Heartburn? | | ☐ Yes ☐ No ☐ Sometimes | | |  |
| How soon after eating? | | |  |  |  |
| Do you ever under/over eat or obsess about food/eating? | | | | |  |
| Do you feel tired after eating? | | ☐ Yes ☐ No ☐ Sometimes | | |  |
| Which meals? | | | | |  |
| Daily water intake: | | | | |  |
| How often do you consume any of the following? | | | | |  |
| Food | | | Number of times/ day or week | |  |
| White Sugar | | |  | |  |
| Caffeine – Coffee/Decaf/Tea | | |  | |  |
| Caffeine – Soda/ Energy Drinks | | |  | |  |
| Caffeine – Other | | |  | |  |
| Raw Foods | | |  | |  |
| Carbonated Water | | |  | |  |
| Alcohol | | |  | |  |
| Recreational Drugs/ Any type of Smoking | | |  | |  |
| Meat | | |  | |  |
| Dairy (Including Cheese) | | |  | |  |
| Sweets/ Dessert | | |  | |  |
| Chips/ spicy snacks | | |  | |  |
| Liquid (Outside of what is already mentioned) | | |  | |  |
| Supplements/ Vitamins | | |  | |  |
| Please list any other information about your diet that may not have been discussed above: | | | | |  |
|  |  |  |  |  |  |
| Urination |  |  |  |  |  |
| Frequency (approx. time/day): | | | | |  |
| Approx. amount/occurrence: | | ☐ A little ☐ Average ☐ A lot | | |  |
| Color: | | | | |  |
| Strong odor?: | ☐ Yes ☐ No ☐ Sometimes | | | |  |
| Bubbles/froth?: | ☐ Yes ☐ No ☐ Sometimes | | | |  |
| Burning?: | ☐ Yes ☐ No ☐ Sometimes | | | |  |
| Do you ever wake up to urinate? How often? | | | | |  |
|  |  |  |  |  |  |
| Bowel Movements |  |  |  |  |  |
| Frequency (times/day or week): | | | | |  |
| Odor: | | | | |  |
| Color: | | | | |  |
| Consistency (long and smooth, small pellet like, etc.): | | | | |  |
| Floats or sinks?: | | | | |  |
| Burning?: | ☐ Yes ☐ No ☐ Sometimes | | | |  |
| Straining?: | ☐ Yes ☐ No ☐ Sometimes | | | |  |
| Mucus?: | ☐ Yes ☐ No ☐ Sometimes | | | |  |
| Blood?: | ☐ Yes ☐ No ☐ Sometimes | | | |  |
|  |  |  |  |  |  |
| Habits |  |  |  |  |  |
| Substance habits (addictions) like smoking or alcohol: | | | | |  |
| Sleep habits: | | | | |  |
|  |  |  |  |  |  |
| Current Medications | | | | |  |
| Prescribed medications: | | | | |  |
| Prescribed medications are: ☐ Effective in controlling condition ☐ Not effective | | | | |  |
| Over the counter medications: | | | | |  |
| Herbs and supplements: | | | | |  |
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| Females | | | | |  |
| Are you pregnant? ☐ Yes ☐ No | | No. of months: | | |  |
| Are you taking birth control pills? ☐ Yes ☐ No | | | | |  |
| Last menstrual period: | | Are your cycles regular? ☐ Yes ☐ No | | |  |
| How many days long is your cycle? | | | | |  |
| How many days between cycles (i.e. days between the first day of each period)? | | | | |  |
| Usual flow: ☐ Heavy ☐ Moderate ☐ Light | | | | |  |
| What color is the blood? | | Any clots? ☐ Yes ☐ No | | |  |
| Do you experience pain during your period? | | | | |  |
| Do you experience tender breasts and/or PMS before your period? | | | | |  |
| Form of birth control: | | | | |  |
|  |  |  |  |  |  |
| Sleep and Energy Levels | | | | |  |
| Typical bedtime: | | | | |  |
| Describe your bedtime routine: | | | | |  |
| Easy or difficult to fall asleep? | | | | |  |
| Do you wake up at night? | | ☐ Yes ☐ No ☐ Sometimes | | |  |
| How many times? | | | | |  |
| Do you dream? | | ☐ Yes ☐ No ☐ Sometimes | | |  |
| Describe themes or emotional quality: | | | | |  |
| Typical wake up time: | | | | |  |
| Do you feel rested when you wake? | | | | |  |
| Describe your morning routine: | |  | | |  |
| Energy slumps during the day? | | ☐ Yes ☐ No ☐ Sometimes | | |  |
| What time(s)? | | | | |  |
| How do you manage them? | | | | |  |
|  |  |  |  |  |  |
| Exercise | |  |  |  |  |
| Frequency of exercise (times per week): | | | | |  |
| Length of time exercising: | | | | |  |
| Exercise type(s): | | | | |  |
| Capacity (%): | | | | |  |
| Do you sweat? | | | | |  |
|  |  |  |  |  |  |
| Stress Levels | |  |  |  |  |
| What do you like to do for fun? | | | | |  |
| If you had no restrictions or responsibilities, how would you spend your day? | | | | |  |
| Please list any volunteer activities/organizations: | | | | |  |
| How many hours do you work each week? | | | | |  |
| How long is your commute to work? | | | | |  |
| How do you get to work? | | | | |  |
| What is your current stress level from 1 to 10? | | | | |  |
| Contributing factors: | | | | |  |
| What do you currently do for stress management? | | | | |  |
| Do you have a support system? | | | | |  |
| Do you feel community connection? | | | | |  |
| Marital status: | | | | |  |
| What is the quality of your relationship with family? | | | | |  |
| What is the quality of your relationship with friends? | | | | |  |
|  | | | | |  |