

**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.

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| --- |
| 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: |  |
|  |
| Family history, maternal: |  |
|  |
| Family history, paternal: |  |
|  |
|  |  |  |  |  |  |
| 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: |  |
|  |  |  |  |  |  |
| 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? |  |
|  |  |