Ojai Lymphatic Therapy
WHOLISTIC LYMPHATIC HEALTH
bodywork . diet . lifestyle

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 allergies	☐ low grade fever	☐ throat/eyes/ears
☐ gas	☐ nausea		☐ excess sleep	☐ chest/lung/heart
☐ bloating	☐ migraines	☐ edema	☐ aches and pains	☐ agni (appetite, digestion)
☐ constipation	☐ vomiting	☐ heaviness	☐ malaise	
☐ hemorrhoids	☐ skin rashes, acne, hives, boils	☐ dullness	☐ lethargy	☐ urine: clear, cloudy, burning, difficult
☐ muscle twitching, cramping, numbness or weakness	☐ bruising	☐ dull, vague pain	☐ lack of energy	☐ nails
☐ joint pain, cracking	☐ excess thirst	☐ cold, clammy hands	☐ lack of appetite	☐ menses
☐ stiffness	☐ burning, sharp pain	☐ difficulty sweating	☐ sinking stool	☐ menopause
☐ shifting, tearing pain	☐ spontaneous bleeding	☐ frequent urination		☐ pregnancy
☐ dry cough	☐ tenderness to touch	☐ excess oily skin		☐ other OB/GYN
☐ cold extremities	☐ excess body heat	☐ excess sleep		
☐ dry skin	☐ interrupted sleep	☐ depression, greed, attachment		
☐ restlessness	☐ anger, rage, envy, judgement, critical	☐ mental lethargy		
☐ worry, fear, anxiety				

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? <u>Food</u> <u>Number of times/ day or week</u> 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?