Patient Information Document

Application For Services

☐ New ☐ Returning

Returning Patients only: *If you have completed the Health History packet in the last year and there have been no changes to the information provided:*

_____ ***(Initial)*** *I certify that there have been* ***no changes*** *to the Health Information and History forms I have previously completed*

Consultation Services Offered to me by the Ayurvedic Institute:

- Determine my mind-body constitution to identify and assess any imbalances that may exist
- Provide information and guidance relevant to helping me nourish, stimulate or balance vital energy
- Develop a plan with me for lifestyle changes that may improve my general health and wellness

Please initial in agreement to the following: Please initial ALL lines below to indicated you that you have read, understand, and agree.

_____ **Patient Information Document:** I have read all information contained in this packet and have been provided with a copy of the Patient Information Document, the originals of which will be kept by The Ayurvedic Institute for at least three years.

_____ **48 Hour Cancellation Policy:** If I need to cancel an appointment and do not cancel more than 48 hours before the scheduled appointment time, I understand that I will be charged full price for the appointment.

_____ **Timeliness:** I commit to attending the scheduled appointment(s) on time. If I do not arrive for my scheduled appointment, I understand that I will be charged full price for the appointment.

_____ **Teaching Facility:** The Ayurvedic Institute is principally a teaching facility. Consultations will be conducted in a private setting, under supervision of a Clinical Supervisor (within the Student Clinics), and additional student observers may be present.

_____ **Consultation Costs:** Supervised ASP 2 Student Clinic Fee Sliding Scale $30 - $50 (Consultations are approx. 75 minutes)
Senior Practitioner Clinic Fee Sliding Scale $70 - $95 (Consultations are approx. 60 minutes)

Your signature below indicates that you have read, understand, and agree to the following:

- I will study the information provided and participate in the design of the health and wellness plan
- I will implement my health and wellness plan according to my ability
- I will notify my primary care provider, if under care, of my intention to begin this health and wellness plan
- I will discontinue any or all of the health and wellness plan elements if any discomfort occurs, and notify the Ayurvedic Institute at 1(505)291-9698, and my primary care provider, if any.
- In the case of disputes or claims that cannot be resolved privately between myself and the Ayurvedic Institute or any employee or student thereof, I agree to submit such dispute or claim to the American Arbitration Association and agree to be bound by their rules and final decision.
- I understand that this is an educational Ayurvedic Consultation and this consultation does not include medical diagnosis or medical treatment, is not a substitute for medical care, and is not an agreement for on-going care.
- I understand that my patient file and health information may be used as part of the education within the classroom, originals of which will be kept by The Ayurvedic Institute for at least three years.
- I understand that The Ayurvedic Institute is not responsible for any herbal contraindications, and I acknowledge that I am solely responsible for discussing any herbal recommendations I receive with my healthcare provider.

I hereby acknowledge and authorize that the information I provide in this consultation and subsequent information accumulated in my health information files may be used in whole or in part as a case study by the instructors of the Ayurvedic Institute for educational purposes. My personal identification will be carefully protected from disclosure.

I hereby apply for services from the Ayurvedic Institute and agree to participate in the development of my health and wellness plan and authorize The Ayurvedic Institute and its practitioners to perform any of the above defined services. By signing, I acknowledge that I understand and agree to all the terms and conditions detailed in the Patient Information Document.

Name (printed) _____ Date _____

Signature of Patient/Guardian (or third party, as appropriate) _____

Health Information and History

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? _____

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 note that **Ayurvedic Consultations do not include medical diagnosis and treatments**. If you are concerned about a medical condition or a latent or potential medical condition you should see a medical doctor.

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) PERSONAL HISTORY: 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 ? _____

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 ☐ Bloating ☐ Gas/Flatulence ☐ Abdominal Discomfort ☐ Gurgling Intestines ☐ Breathlessness	☐ Quick digestion with ☐ Acid Indigestion ☐ Heartburn ☐ Burning pain ☐ Still hungry after eating ☐ Nausea ☐ Vomiting	☐ Slow digestion with ☐ Feeling of heaviness ☐ Lethargy ☐ Sleepy after eating ☐ Low energy after meals ☐ Excess mucous secretions
Appetite	☐ Irregular ☐ Sometimes eats at midnight	☐ Excess hunger ☐ Sharp hunger ☐ Desire to eat large amounts of food ☐ Strong unbearable appetite ☐ Feels hypoglycemic	☐ Emotional eating (No urge for food but still eats) ☐ Dull / No appetite
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 ☐ Redness ☐ Boils ☐ Ruddy	☐ Excess oily ☐ Thick ☐ Pallor ☐ Cold/clammy ☐ Lustrous ☐ Itchy
Sweating	☐ Scanty or no sweat	☐ Excess ☐ Profuse with body odor	☐ Cold/clammy

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

_____