Purely Ayurveda

Dear client,

I would like our time together to be as productive and educational as possible. In order to avoid spending a great deal of time simply gathering information, I have enclosed a form that you can complete prior to our appointment. If you are taking complex supplements that are not well known, you may wish to consider bringing them to our meeting. Thank you and see you soon!

I look forward to working with you.

Sincerely,
Jennifer

Contact / Personal Information	
Name:	Phone:
Street Address:	City, State, Zip:
Birthdate:	Birth time / Place:
Profession:	Marital Status:
Email Address:	

Please list any major medical problems you have had, such as asthma, hypertension, stroke:		
Medical Condition	**Date Started**	**Hospitalized for this?**
1)		Yes ☐ No ☐
2)		Yes ☐ No ☐
3)		Yes ☐ No ☐
4)		Yes ☐ No ☐
5)		Yes ☐ No ☐
6)		Yes ☐ No ☐
7)		Yes ☐ No ☐

Please list any surgeries you have had:		
Surgery	**Date**	**Reason For Procedure**
1)		
2)		
3)		
4)		
5)		
6)		
7)		

Are you allergic to any medications or supplements:	
Medication or Supplement Name	**Reaction**
1)	
2)	
3)	
4)	
5)	

Please list other physicians participating in your care:	
Name	**Specialty**
1)	
2)	
3)	
4)	
5)	

Please list any medications you take regularly with dose and frequency (include birth control pills and over-the-counter medications):	
Medications:	
1)	7)
2)	8)
3)	9)
4)	10)
5)	11)
6)	12)

Please list any herbs or nutritional supplements you take:

Supplements:	
1)	7)
2)	8)
3)	9)
4)	10)
5)	11)
6)	12)

Please list any diseases or conditions in your family:	
Disease or Condition	**Which Relative Has This?**
1)	
2)	
3)	
4)	
5)	
6)	
7)	

Lifestyle:		
Sleep:	**Elimination (Bowel Movements):**	**For Woman:**
Bedtime?	Frequency?	Menstruating?
Rising Time?	Well-formed?	Time Between Periods?
Awakenings?	Same Time?	Length of Period?
Rested Upon Arising?		Symptoms?
Smoking: Yes No If yes, how many per day?		

Diet:

Typical Breakfast:	
Typical Lunch:	
Typical Dinner:	
Typical Snacks:	
What Do You Drink Typically:	Do You Drink Alcohol (What/How Much/ How Often):
Do You Take Caffeine (If so, what form and how much / how often):	

Digestion:
Are There Any Foods You Don't Tolerate? (List them.)
Heartburn ☐ Gas ☐ Bloating ☐ Sluggish Feeling After Eating ☐
How Soon After Eating Are You Hungry Again?
Describe Your Appetite:

Exercise:	
What Kinds of Things Do You Do For Exercise?	
Frequency of Exercise (Days per Week):	How Much Time (Each Exercise Session):
How Do You Feel After Exercising?	