Kripalu ayurveda intake form

Date ____________________

personal information

First name ____________________

Last name ____________________

Date of birth ____________________

Address ____________________

City ____________________ State ____________ Zip code ____________

Cell phone ____________________ Home phone ____________________

Work phone ____________________ E-mail ____________________

Current occupation ____________________

Emergency contact ____________________ Phone number ____________________

program information

Why are you interested in an Ayurvedic consultation? ____________________

____

____

____

present health

Please describe your present health problems and their duration.

1. ____________________

____

2. ____________________

____

3. ____________________

____

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How long have you had the chronic conditions about which you are consulting us?

☐ Less than 6 months ☐ 6 months to 2 years ☐ 2–5 years ☐ more than 5 years

How have your health problems progressed since they began?

☐ Stable ☐ Gradually improving ☐ Rapidly improving ☐ Fluctuating
☐ Gradually worsening ☐ Rapidly worsening

Please indicate the overall intensity of your symptoms.

☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

How often are you having pain or discomfort?

☐ Less than once per week ☐ Several times per week ☐ Once a day
☐ Several times per day ☐ Most of the time

Do you take any nonprescription drugs or vitamins or any other supplement/s? Please list them.

Are you currently under the care of a family physician or any other health professional?

If yes, include details.

Do you currently take medication and/or receive medical treatment for your health condition(s)?

If so, include all medications, treatments, and dosages.

Do you have any past medical history or problems (i.e., illness, trauma, emotional stress, addictions, drug abuse, or anything else that will help us clearly understand your health condition)?

Is there a family history of the health problem(s) listed above? ☐ Yes ☐ No If yes, please specify.

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Fill in as appropriate.

	child	myself	father	mother	brother(s)	sister(s)	spouse	other
Age (if living)								
Age (at death)								
Cause of death								
Anemia								
Cancer								
Diabetes								
Epilepsy								
Glaucoma								
Heart disease								
High blood pressure								
Hay fever								
Hives								
Kidney disease								
Mental illness								
Rheumatoid arthritis								
Tuberculosis								
Syphilis								
Stroke								
Other								

Any other family illnesses or concerns? ____________________

____

____

Health as a child: ☐ Good ☐ Fair ☐ Poor

Childhood illnesses: ☐ German measles ☐ Measles ☐ Mumps ☐ Bronchial problems ☐ Scarlet fever ☐ Diphtheria ☐ Other

Immunizations/vaccinations: ☐ Smallpox ☐ Polio ☐ Typhoid ☐ Mumps ☐ Tetanus ☐ Influenza ☐ Other

Have you ever experienced a reaction to vaccination(s)? ____________________

____

____

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daily routine (dinacharya)

Do you get up early? ☐ Yes ☐ No At what time? ____________________

Do you go to bed early? ☐ Yes ☐ No At what time? ____________________

Do you sleep during the day? ☐ Yes ☐ No At what time? ____________________

How do you generally feel when you wake up in the morning?

☐ Fresh and rested ☐ A little tired ☐ Moderately tired ☐ Very Tired

In what direction does your head point during sleep?

☐ North ☐ East ☐ South ☐ West
☐ Northeast ☐ Northwest ☐ Southeast ☐ Southwest

How would you describe your experience of sleep?

☐ Sound; normal duration ☐ Light, interrupted ☐ Not enough
☐ Too heavy and/or long ☐ Difficulty falling asleep ☐ Difficulty waking up
☐ Awaken too early ☐ Frequent nightmares

What position do you sleep in?

☐ On back ☐ On stomach ☐ Left side ☐ Right side ☐ Other

How regularly do follow your ideal routine (i.e., go to bed early, eat meals on time, exercise regularly)?

☐ Very regularly ☐ Somewhat regularly ☐ Irregularly

Describe your bowel movements.

☐ Once every 2–3 days ☐ Once daily ☐ 2–3 times per day ☐ First thing in the morning
☐ Late in daytime ☐ Immediately after meals ☐ Immediately after dinner
☐ Need laxative daily ☐ Other (please specify) ____________________

Bowel nature:

☐ Soft ☐ Medium ☐ Hard

Bowel movement associated with:

☐ Pain ☐ Blood ☐ Mucous ☐ Foul smell
☐ Other

Do you delay or suppress any of the following?

☐ Sleep ☐ Bowel movements ☐ Gas ☐ Urination ☐ Yawning
☐ Burping ☐ Thirst ☐ Breathing ☐ Semen ☐ Hunger
☐ Sneezing ☐ Tears

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Do you travel often? ☐ Yes ☐ No

Do you do self-massage with oil daily? ☐ Yes ☐ No

exercise

How often do you exercise?

☐ Daily ☐ Weekly, four times ☐ Weekly, three times ☐ Weekly, twice

☐ Weekly, once ☐ Not at all

What type of exercise do you do? ______________________________

How long do you exercise each time? ______________________________

Rate the intensity of your exercise. ☐ Light ☐ Moderate ☐ Vigorous

eating habits

Food Groups	Daily	Weekly	Monthly	Never
Grains/cereals				
Vegetables				
Fruits				
Dairy				
Eggs				
Poultry				
Meat (beef, pork, etc.)				
Seafood				
Sugar/honey				
Desserts				
Juices				
Other				

Please describe what you typically eat.

Breakfast ______________________________

____

Lunch ______________________________

____

Dinner ____________________

____

Snack ____________________

____

Do you eat between meals? ☐ Yes ☐ No

Do you eat your meals at regular times? ☐ Yes ☐ No

Which is your biggest meal? ☐ Breakfast ☐ Lunch ☐ Dinner

Rate your digestion. ☐ Good ☐ Fair ☐ Bad

How much water do you drink per day? ☐ None ☐ 1–2 Glasses ☐ 3–4 Glasses ☐ 5–6 Glasses ☐ 7+ glasses

Indicate your eating habits.

☐ Eat with my full attention on food ☐ Converse a lot while eating ☐ Eat very quickly
☐ Watch television while eating ☐ Rarely sit down to eat

Describe your diet.

☐ Vegan ☐ Lacto-vegetarian ☐ Lacto-ovo vegetarian
☐ Other

If you are a nonvegetarian, please indicate the proteins you eat.

☐ Beef ☐ Pork ☐ Chicken ☐ Turkey ☐ Seafood ☐ Eggs
☐ Other

Indicate which best describes your sense of taste (if any).

☐ Loss of taste ☐ Sweet taste in mouth ☐ Sour taste in mouth
☐ Pungent taste in mouth ☐ Bitter taste in mouth

What taste(s) do you like or crave?

☐ Sweet ☐ Salty ☐ Sour ☐ Bitter
☐ Hot/Spicy ☐ Starches ☐ Oily

Are there particular foods that create discomfort when you eat them?

☐ Sweet ☐ Salty ☐ Sour ☐ Bitter
☐ Astringent ☐ Dairy products (including cheese)

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miscellaneous

Do you practice any type of meditation? Please explain. ____________________

____

Do you practice yoga? Please explain. ____________________

____

Which type of weather makes you feel most uncomfortable?

☐ Cold ☐ Hot ☐ Cool and damp

Are you allergic to any substances?

☐ Food ☐ Pollen ☐ Dust

☐ Other (please specify)

Do you smoke cigarettes (or other substances)? ☐ Yes ☐ No

If yes, how many per day? ☐ 1/2 pack ☐ 1 pack ☐ 2 packs ☐ More than 2 packs

How often do you drink alcohol?

☐ Never ☐ Less than once a week ☐ About once a week

☐ Several times a week ☐ Once a day ☐ More than once a day

How much at a time? ____________________

How often do you drink caffeinated beverages?

☐ Never ☐ 1 cup daily ☐ 2–3 cups daily ☐ 4–5 cups daily

How would you rate your usual energy level?

☐ Very high ☐ High ☐ Moderate ☐ Low ☐ Very low

Do you experience any of the following?

☐ Depression ☐ Anxiety ☐ Fear or panic ☐ Loneliness ☐ Worry

☐ High stress level ☐ Anger ☐ Lack of memory ☐ Light-headedness

☐ Lack of energy ☐ Suicidal thoughts or attempts ☐ Irritation

social history

How are your family relationships? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How is your social life? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

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How is your mental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How is your career? ☐ Love it ☐ Like it ☐ It's bearable ☐ It's unbearable

How purposeful does your life feel?
☐ Completely ☐ Somewhat ☐ Neutral ☐ Purposeless

Rate your spiritual life.
☐ Fully satisfying ☐ Somewhat satisfying ☐ Neutral ☐ Empty

As a child, did you experience any abuse or trauma? ☐ Yes ☐ No

☐ Emotional ☐ Physical ☐ Sexual ☐ Verbal ☐ Other (please specify)

____

____

____

for men only

Please indicate which of the following areas are troublesome (if any).
☐ Hernias ☐ Sexual difficulty ☐ Urination ☐ Erection problem ☐ Libido
☐ Birth control ☐ Prostate problems ☐ Discharge or sores ☐ Venereal disease
☐ Testicular masses

for women only

Age menses began: ______________________________

Which of the following describes your menstruation?
☐ Regular ☐ Irregular ☐ Too frequent ☐ Absent ☐ Ceased due to menopause

How many days does your menstrual period last?
☐ 1–4 days ☐ 5–7 days ☐ More than 1 week ☐ Irregular throughout the month
☐ Other ______________________________

How is your menstrual flow?
☐ Normal ☐ Heavy ☐ Light ☐ Abnormal vaginal discharge

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Do you have any associated symptoms (before or during menstruation)?

☐ None ☐ Pain ☐ Fluid retention ☐ Migraine ☐ Depression
☐ Acne ☐ Tension ☐ Nightmares ☐ Frustration ☐ Loneliness

Do you have any discharge outside of your menstrual period? ☐ Yes ☐ No

Do you ever experience pain during intercourse? ☐ Yes ☐ No

Are you pregnant now? ☐ Yes ☐ No ☐ Don't know

Do you have any sexual difficulties? ☐ Yes ☐ No

If yes, please explain. ___________________________

____

Do you take contraceptive pills or use other forms of birth control? ☐ Yes ☐ No

If yes, please explain. ___________________________

____

Number of previous pregnancies ___________________________

Do you have any history of abortion, miscarriage, or problems related to pregnancy or labor? If yes, explain.

____

____

How many children do you have? ___________________________

How old are your children? ___________________________

Do you do a breast self-exam regularly? ☐ Yes ☐ No

Do you experience any of the following? ☐ Pain or tenderness ☐ Lumps ☐ Nipple discharge
☐ Other ___________________________

other comments (please include anything else you would like us to know)

____

____

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I understand that this is an educational Ayurvedic consultation for the purpose of helping me improve my health and wellness. I understand this does not include medical diagnoses or treatment and is not a substitute for medical care or an agreement for ongoing care.

____

Client signature Date

statement of understanding

- I understand that ____________________ is an Ayurvedic Consultant and Educator who provides me with infomation on the Ayurvedic approach to health care, which may affect my diet and health in a positive way.
- I understand that ____________________ is not a medical doctor or licensed medical practitioner, has not presented herself as such, and does not seek to diagnose, treat, or prescribe for disease or other pathological conditions.
- I agree that I am interested in enhancing my own abilities to heal and establish health in mind and body, and this is the reason I have sought Ayurvedic consulting services.
- I agree that I may consult a licensed physician for any concern, at any time, about any disease or pathology that now exists or arises during my professional relationship with ______________.
- Furthermore, I understand that ____________________ encourages regular medical check-ups from a licensed medical professional of my choice, and that any medication that I am now taking upon my licensed physician's advice, or will take in the future, is taken strictly according to my licensed physician's directions. Only a licensed physician of my choice can advise on medication dosages or the discontinuance or resumption of such medications.

My signature below acknowledges the above statements as fully read and understood.

____

Client's signature Date

____

Ayurvedic Consultant's signature Date

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constitution (prakriti) evaluation

Avoid the temptation to evaluate yourself based on how you would like to be rather than how you actually are. If in any category there have been great changes at various times in your life, please select "vata" as your answer even if the vata description in that category does not accurately describe you as you are today.

If in any category you feel that you belong partly in one constitution and partly in another, choose both. If in any category you feel that you fit into all three constitutions, select the two that best characterize you. Whenever you have significant doubt or confusion, select vata. While evaluating yourself keep in mind that

- Vata is cold, dry, mobile, and irregular
- Pitta is hot, oily, sharp, and irritable
- Kapha is cold, wet, stable, and soft.

Prakriti evaluation, or body typing, is neither a way to reinforce limitation nor a source of convenient labeling. It is a tool for self-examination and self-development for use in locating and settling into one's own niche in the cosmos.

Physical Makeup	Vata	Pitta	Kapha
Body frame	Thin and unusually tall or short	Medium body	Stout, stocky, or large/broad body
Bones	Light, small bones and/ or prominent joints	Medium bone structure	Heavy/dense bone structure
Body weight	Low	Moderate	Can be overweight
Skin	Dry, rough, cool	Soft, oily, warm	Thick, oily, cool, pale, glistening
Hair	Dry, brown, black, coarse, curly, brittle	Soft, fine, often straight, oily, early grey, baldness	Thick, oily, lustrous, wavy
Teeth	Irregular, protruded, crooked, thin gums	Moderate, yellowish teeth, soft gums,	Regular, strong, white, healthy
Eyes	Small, brown, black, iris: grey, violet, slate blue	Medium, sharp, penetrating, hazel green, light or electric blue	Big, blue or brown iris, thick eyelashes, calm eyes
Lips	Thin, small, dry	Medium, soft, red	Thick, large, smooth
Chin	Thin, angular	Tapering	Rounded, double
Neck	Thin, tall	Medium	Big, folded
Fingers	Thin, long, tapering	Medium	Thick, broad, short
Endurance	Fair	Good	High
Score			

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Physical Functions	Vata	Pitta	Kapha
Appetite	Variable, scanty	Good, excessive	Steady, constant
Thirst	Variable	Excessive	Less
Sweat/body odor	Low, scanty, no smell	Profuse, hot, strong smell	Moderate, cool, pleasant smell
Sleep	Light, interrupted	Moderate, 6–8 hrs	More than 8 hrs
Speech	Talkative, may ramble	Speaks purposefully	Speaks less cautiously
Elimination	Irregular, dry, hard, tendency toward gas and constipation	Regular, soft, sometimes loose	Regular, solid, well formed
Physical activity	Fast and very active	Medium	Slow and steady
Sexual activity	Lower, variable	Moderate	Good
Weight	Hard to gain, easy to lose	Easy to gain, easy to lose	Easy to gain, hard to lose
Climate preference	Prefers warm	Prefers cool	Enjoys changes of seasons
Taste preference	Prefers sweet, sour, salty	Prefers sweet, bitter, or astringent	Prefers pungent, bitter, or astringent foods
Sensitivities	Cold, dryness, wind	Heat, sunlight, fire	Cold, damp
Score			

Psychological	Vata	Pitta	Kapha
Mind	Restless, always active	Aggressive, intelligent	Calm
Dreams	Fearful flying, jumping, running	Fiery, passionate, anger, violence	Watery, rivers, oceans, swimming, romantic
Temperament	Nervous, changeable	Motivated, aggressive	Calm, content, conservative
Faith	Changeable	Determined fanatic	Steady, slow to change
Memory	Easily notices things but easily forgets	Sharp	Slow to take notice but won't forget
Interest/habits	Dancing, artistic activities, talking	Competitive ventures, debate, politics, hunting	Family and social gatherings, cooking, collecting
Positive emotions	Adaptability	Courage	Love
Negative emotions	Feels fear often	Often afflicted with anger	Attachment
Finances	Spends on trifles	Spends money on luxuries	Good money preserver
Moods	Changes quickly	Changes slowly	Steady, non-changing
Memory	Short-term is best	Good general memory	Long-term is good
Score			