Ayurvedic Center for Well Being

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Client History

Name: _____ Date: _____

Address: _____

City/State/Zip: _____

Phone Number: _____ Date Of Birth: _____

Recommended By: _____ email: _____

Reason for Consultation: _____

_____

_____

What are your symptoms?

#1: _____

How Long have you had them? _____

#2: _____

How Long have you had them? _____

#3: _____

How Long have you had them? _____

#4: _____

How Long have you had them? _____

#5: _____

How Long have you had them? _____

#6: _____

How Long have you had them? _____

Occupation _____ Do you enjoy your work? _____

Rate level of job stress _____ Source of job stress _____

Do you experience stress in any particular part of your body? _____

Married _____ Single ____ Divorced _____

How many children at home? _____ Pregnancies _____

How do you feel about your current relationship status?

_____

If in a relationship, are your happy? _____

Family life stresses _____

Medical History

What major illnesses or operations have you had in your life?

_____ _____

_____

_____

_____

Have you had a medical exam in the past year? _____

Results of exam?

_____

Are you on any medication? ___No ___Yes Which Ones:_____

Have you consistently experienced any of the following:

___ Abdominal Pain
___ Allergies
___ Arthritis
___ Asthma: -Childhood or
-Adult onset
___ Blurred Vision
___ Circulatory Problems
___ Constipation
-When _____
___ Diarrhea
___ Digestive Problems
-When _____
___ Headaches
___ Fatigue / Exhaustion
Why _____
___ High / Low Blood Pressure
___ Insomnia
When _____

___ Low Blood Pressure _____
___ Menstrual Regularity _____
___ Migraines: When _____
_____
How often _____
___ Miscarriage
___ PMS -Symptoms: _____
_____
___ Respiratory Probems _____
Do you experience: Congestion, dryness, phlegm & where in body_____
_____
___ Sinus Infections
___ Skin Problems
What kind _____
___ Stomach Ulcers
___ Varicose Veins

General Health Information

Do you have a healthy diet: ___ Always ___ Most of the time ___ Sometimes ___ Never

Exercise: ___Once per day ___Once per week ___More than 1 x week ___Seldom ___Never

What types of exercise: _____

Family History

Illnesses from your Father's side of family:

Illnesses from your Mother's side of family:

10 % off when you refer a friend!