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Intake Form

Please take your time in filling out the following information. The following questions may seem in depth and personal, but they are necessary in order for you and I to assess your current condition. Holistic consultations take many aspects of the client's physical, mental, and spiritual health into consideration. This information is strictly confidential, and will be viewed without judgment. Your honesty will aid you in getting the most benefits from this consultation.

Name:_____
Date:_____

Address:_____
_____

Phone Number:_____**Alternate phone number:**_____

Email _____

Male or Female (circle one)
Birthdate:_____

Marital/partner status:_____**# of children:**_____**Ages**_____

Preferred method of contact:_____

Occupation:_____

Emergency contact & phone number:_____

FINANCIAL POLICY AGREEMENT

3. Each initial consultation through Lasya Ayurveda is $150.00.
4. Each follow-up visit through Lasya Ayurveda is $85.00.Any herbal formulas will be an extra charge, and this may include a charge for shipping and preparation.
5. Payment may be made via cash, or credit card. Long distance consultations must be paid for before the time of the appointment and can be paid via credit card or paypal.
6. If you miss an appointment without giving 24 hours notice, a $25.00 fee is charged to your account.

I have read and understood the financial policies of Lasya Ayurveda.

Patient's Signature:_____ **Today's Date:**_____

What do you expect from this visit?

_____

_____

What are your long term goals from working with me?

_____

_____

What level of change to your living habits are you willing to make in order to improve your health? Please circle your preference with "0" being no commitment, and "10" being total commitment.

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Please list any health concerns, beginning with those that you feel need the most attention. Please include the amount of time you have been dealing with each problem, when they happened, if they were connected to any mental or physical trauma, and what was happening in your life at the time they began. Also include any other information that you think may seem relevant. (You may use the back of this page if necessary.)

1._____

_____

_____

2._____

_____

_____

3._____

_____

_____

4._____

_____

_____

Are there any emotional issues that you would like to address today or that you feel may be related to your problems? Please explain briefly. We can discuss this more during the
appointment._____

_____

Please list any medications you are currently taking including asprin, tylenol, laxatives, steroids, diet aids, sedatives, and sleeping aids

_____

_____

Please list any natural remedies you are currently taking including herbs, homeopathics, and flower essences.

_____

_____

Please list any allergies or sensitivities to medications, foods, household chemicals, animals, or anything else.

_____

_____

PAST MEDICAL HISTORY

Who are your current health care providers? Please provide name, type of service, and phone # if possible.

_____

_____

Please list any illnesses or hospitalizations and include dates of diagnosis or treatment.

_____

_____

Please list any major illnesses, emotional or physical trauma or accidents not previously
mentioned_____

_____

_____

Please list any recent physical exams or diagnostic tests performed with the date and any findings. Include blood work, urine tests, pelvic, prostrate, or mammograms.

_____

Are you pregnant? _____

PERSONAL LIFE

What are your personal goals in life?_____

_____

What would you like to change most in your life?

_____

_____

What behaviors, habits or thoughts would you like to eliminate?

_____

_____

Substance Use

Do you drink alcohol? Yes No ow often?_____/per week or month (circle)
What do you normally drink?_____

Do you use tobacco or have you in the past? _____
If yes, how much per day?_____

Have you ever smoked marijuana? Yes No
If yes, how much per day?_____

Do you now or have you used recreational drugs in the past?

_____

_____

Have you ever been exposed to toxic chemicals or solvents? Yes No
If yes, please explain:

_____

_____

REGULAR PRACTICES

❒ Exercise/Hatha Yoga *(specify)*	❒*None/Never*	❒*Occasional* ❒*Daily*	❒*Several times per week* ❒*Several times per month*
❒Team	❒*None/Never*	❒*Occasional* ❒*Daily*	❒*Several times per*

Sports/Recreation *(specify)*		*y*	*week* ❒ *Several times per month*
❒Travel (*Include commute)*	❒*None/Never*	❒*Occasional* ❒ *Dail y*	❒*Several times per week* ❒ *Several times per month*
❒Spiritual Practices *(specify)*	❒*None/Never*	❒*Occasional* ❒ *Dail y*	❒*Several times per week* ❒ *Several times per month*
❒Meditation/Prayer *(specify)*	❒*None/Never*	❒*Occasional* ❒ *Dail y*	❒*Several times per week* ❒ *Several times per month*
❒Other *(include creative activities)*	❒*None/Never*	❒*Occasional* ❒ *Dail y*	❒*Several times per week* ❒ *Several times per month*

RELATIONSHIP

a. Please indicate how nourished you feel in your relationship:

1 2 3 4 5 6 7 8 9 10

(1 being the least nourished, 10 being the most nourished)

b. How often do you engage in sexual activity (with a partner and/or masturbation)

❒*Daily* ❒*Several times per week* ❒*Several times per month* ❒*Occasionally* ❒ *Not at all*

Is your current sexual activity satisfactory? ❒Yes ❒No

Food Choices: (please be as detailed as possible)

List below what types of foods you eat on a regular basis.

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

_____

List any foods you exclude from your diet:

_____

_____

DAILY LIQUID INTAKE (Indicate number of 8oz cups per day)

❒Plain Water_____

❒Caffeinated Coffee/Tea___ ❒Herbal Tea or Juice_____ ❒Cow or Goat Milk _____

❒Sodas_____ ❒Decaffeinated Coffee/Tea____ ❒Grain/Nut/Soy Milk _____

At what temperature do you prefer to drink? ❒Hot ❒Room Temp. ❒Cold

FAMILY MEDICAL HISTORY
Please indicate Mother's side (M), Father's side (F), or Siblings (S)

❒High Blood pressure _____	❒Mental Disorder _____
❒Cancer_____ ___	❒Diabetes _____
❒Stroke _____	❒Other _____
❒Heart Disease _____	_____ __

Females
Age of first menses_____ How many days in your cycle?¨_____
Duration of menses_____
List any other symptoms or imbalances related to your menses. _____
_____

Ayurvedic History
For each category please identify your tendency over time by placing an "X" in the box that is most appropriate for you. If you are unsure or would like to speak to your practitioner about this please place a check in the column to the right.

Appetite	❒I prefer to eat frequently but my hunger level is variable, and I often forget to eat. Practitioner use only V P	❒I have a strong appetite. I prefer to eat 3xs/day and rarely skip meals. Practitioner use only V P	❒I prefer to eat 2-3xs/day, but I can go without eating with no discomfort. Practitioner use only V P	
Appetite	❒If I miss a meal, I often get light-headed or anxious. Practitioner use only V P	❒If I miss a meal, I often get irritable or angry. Practitioner use only V P	❒If I miss a meal, it doesn't really bother me.Practitioner use only V P	
Digestion	❒After eating, I often experience gas or bloating. Practition er use only V P	❒After eating, I often experience heartburn or acidity. Practitioner use only V P	❒After eating, I often feel heavy or sleepy.Practitioner use only V P	
Elimination	❒I tend to have irregular bowel movements one time per day or lessPractitioner use only V P	❒I tend to have 1-2 bowel movements daily, usually with regularity and ease. Practitioner use only V P	❒I tend to have one bowel movement per day with no straining or difficulty. Practitioner use only V P	
Elimination	❒My bowel movements are often dry and hard. At times I may strain or push. Practitioner use only V P	❒My bowel movements are usually well-formed, but sometimes they are loose and may burn.Practitioner use only V P	❒My bowel movements are usually well-formed, slow and easy.Practitioner use only V P	
Weight	❒I usually don't gain weight very easily. Practitioner use only V P	❒When I gain weight, it is easy to lose it. Practitioner use only V P	❒I gain weight easily and lose it slowly. Practitioner use only V P	
Body Temperature	❒My hands and feet often feel cold, and I prefer warmer climates. Practitioner use only V P	❒I am warm most of the time no matter what the climate is.Practitioner use only V P	❒I adapt easily to most conditions, but tend to feel cool. Practitioner use only V P	

MENTAL & EMOTIONAL PATTERNS

Stress	❒Under stress I often become worried or overwhelmed. □ □ P ractitioner use only V P	❒Under stress I often become irritable, but usually rise to the challenge. Practitioner use only V P	❒Under stress, I often withdraw to observe or become reclusive. Practition er use only V P	
Decision Making	❒I am changeable and often have difficulty making decisions. Practitioner use only V P	❒I make decisions easily, but can change my mind with new information. Practitio ner use only V P	❒I am careful but easy-going about decisions. Practitioner use only V P	
Projects	❒I like to start projects, but at times have difficulty finishing them. Practitioner use only V P	❒I like to start and finish projects. Completion is important to me. Practitioner use only V P	❒I like working on a project, but prefer to let others start them. Practitioner use only V P	
Personality	❒When I am balanced I feel creative, enthusiastic, and vivacious. Practitioner use only P	❒When I am balanced I feel perceptive, disciplined, and logical. Practitioner use only P	❒When I am balanced I feel nurturing, calm, and devotional. Practitioner use only P	

CHALLENGING PATTERNS

Please indicate any physical and emotional patterns that you find challenging in each symptom below.
Assign a **Frequency** (# of times per week month or year) and **Intensity** (a # from 1-10)
PATIENT EXAMPLE:

	Frequency	Intensity
Acid Reflux	3x wk	4

Intensity
1-3=MILD DISCOMFORT
4-6=MODERATE DISCOMFORT
7-10=SEVERE DISCOMFORT

DIGESTION

	Frequency Number of times per week, month or year	Intensity (1-10)
Excessive gas		
Excessive belching		
Acid reflux		
Burning indigestion		

Nausea or vomiting		
Sleepy after eating		
Heaviness after eating		
Bloated after eating		

EMOTIONS

	Frequency Number of times per week, month or year	Intensity (1-10)
Worry		
Anxiety		
Overwhelm		
Self-destructiveness		
Anger		
Resentment		
Critical/Blaming		
Intense		
Lethargic		
Melancholy		
Depression		
Stubborn		

ELIMINATION

	Frequency Number of times per week, month or year	Intensity (1-10)
Constipation (less than 1 BM/day)		
Alternating constipation & diarrhea		
Food Particles in stool		
Diarrhea		
Rectal pain or hemmorhoids		
Mucus in stool		
Abdominal pain		