Kerala Ayurveda Academy & Wellness Center

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Health Seeker Intake form

These forms are indicative of the nature of questions and flow. Actual dimensions and spacing suggested are different.

Today's Date:		Age:	Gender: ❑ F ❑ M
Name (Last, First, MI):		Height:	Weight:
Address (No. Street):		**Date of Birth:**	Place of Birth:
City, State, Zip Code:		**Phone** (c) (h)	(w)
E-mail:	**Occupation:**	Married Single	Divorced/Separated Cohabitating Widowed
Emergency Contact Name: **Phone:**		**Referred by:**	

What is your ethnicity?

Native American	Asian	Hispanic	Mediterranean
African American	South Asian	Caucasian	Northern European
Other			

With whom do you live? *Include children, parents, other occupants and pets with ages*

What do you hope to achieve with your health consultation today?

Main problem(s) you would like help with

Describe problem	Since	Mild/Moderate/Severe	Attempted treatment and response

Mild – some discomfort, Moderate – creates much trouble, but can continue regular activities, severe – restricts your daily routine

Are you diagnosed with any medical conditions?

Conditions	Since when	Control status	Treating physician, affiliation

Are you taking any prescription medications?

Medication Name	Started in	Dosage	Prescribed by

Are you taking any herbal or alternative medicine?

Name	Started in	Dosage	Prescribed by

Are you taking any vitamins or nutritional supplements?

Name with dose of main ingredients	Since when	Regularly	Given by

e.g. One a Day, Centrum, other vitamins

Were there any diseases that you suffered from earlier?

Disease	From when to when	Treatment – drugs, exercise, etc.

Include major infections like typhoid, malaria, hepatitis

Have you had any kind of surgery or minor procedures performed on you?

Procedure	When	Who and where performed

Include any Panchakarma, Acupuncture and other treatments here as well

Please list any hospitalizations

Year	Condition	Procedure done

Family History *Fill only the positive yes as 'Y' or a tick mark*

	Father	Mother	Brother(s)	Sister(s)	PGM	PGF	MGM	MGF
Diabetes								
Hypertension								
Heart Disease								
Stroke								
Asthma								
Cancer (type)								
Hypothyroid								
Arthritis								
Other								
If not living, age at and cause of death								

PGM, PGF = Paternal grandmother, grandfather; MGM, MGF =maternal grandmother, grandfather

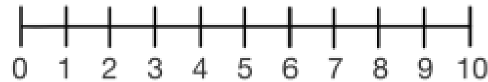
How much do you move?

Activity	**Intensity**	**Hours**	**Days/ week**	**Since**
How often do you break a sweat with exercise? (times/week)				
How many hours do you watch TV every week?				
Do you watch TV, read or surf while eating meals?				

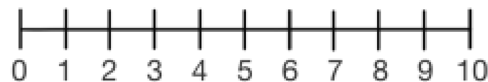
Do you connect with yourself? How and how often? *Hobbies/music/ meditation/ community service etc.*

On a scale of 1 to 10, please indicate in the past week:

How stressed you have been? *0 – not at all, 10 extreme*

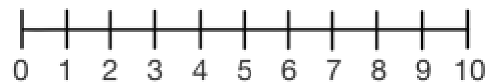


What is your energy level? *0 – very poor, I can barely get through the day, 10 – excellent, I can do more!*



Rate on a scale of 0 to 10, how hungry do you feel at different meal times?

0 – not at all 1-3 – mildly hungry 4-7 moderately hungry, 8-9 – quite hungry 10 – very hungry!



	Example	Morning	Mid -morn	Lunch	Snack	Evening	Dinner	Bedtime
Time	11am							
How hungry	8							

Rate on a scale of 1-5 how the following applies

If 1= Always, 2= Often, 3=Sometimes, 4=Rarely, 5=Never

	Rate	***If 3 or below, it indicates***
Is the above pattern mentioned irregular?		*Vāta (Vishama)*
Can you skip meals easily?		*Kapha/Āma (Manda)*
Are you mostly always ready to eat – whatever the time of the day it maybe?		*Pitta (Tikshna)*
If hunger is not gratified, do you feel uncomfortable or irritable?		*Pitta (Tikshna)/ (Vāta)*
Do you end up feeling fuller earlier than expected at the start of a meal?		*Āma/ Vāta (Manda/Vishama)*
Are there times when even little quantity of food doesn't get digested for a long time?		*Āma (Manda)*
Does your food get digested well on some days and sometimes not?		*Vāta (Vishama)*

Habits *Please indicate usage: none, light, moderate, or heavy. Add comments where significant.*

	Heavy	Moderate	Light	None	Comments
Alcohol	❑	❑	❑	❑	
Coffee	❑	❑	❑	❑	
Tea	❑	❑	❑	❑	
Tobacco	❑	❑	❑	❑	
Marijuana	❑	❑	❑	❑	
Other	❑	❑	❑	❑	

Personal preference

Which weather do you prefer?	Warm / cool/ both
Which extreme of weather are you unable to tolerate?	Hot / Cold / Neither
Which taste do you prefer?	Sweet/ Sour/ Salty/ Hot/ Bitter/ Astringent
How thirsty do you feel?	Often/ Moderate/ Not much
Do you sweat easily?	Often/ Not that much/ rarely

Please indicate below any symptoms you have experienced in the last three months:

General

- ❑ Poor appetite
- ❑ Cravings
- ❑ Change in appetite
- ❑ Peculiar tastes/smells
- ❑ Strong thirst – hot
- ❑ Strong thirst – cold
- ❑ Weight gain
- ❑ Weight loss
- ❑ Poor sleep
- ❑ Fatigue
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Fevers
- ❑ Chills
- ❑ Tremors
- ❑ Poor balance
- ❑ Localized weakness
- ❑ Bleed/bruise easily
- ❑ Sudden energy drop
- ❑ *Time(s) of day:*

Skin and Hair

- ❑ Rashes
- ❑ Skin tags
- ❑ Itching
- ❑ Change in skin/hair texture
- ❑ Hives
- ❑ Pimples
- ❑ Recent moles
- ❑ Loss of hair
- ❑ Dandruff
- ❑ Other skin/hair problems:

Head

- ❑ Dizziness
- ❑ Facial pain
- ❑ Migraines
- ❑ Headaches
- ❑ Other head/neck problems:

Eyes, Ears, Nose and Throat

- ❑ Glasses
- ❑ Poor vision
- ❑ Cataracts
- ❑ Eye strain
- ❑ Night blindness
- ❑ Blurry vision
- ❑ Color blindness
- ❑ Eye pain
- ❑ Spots in vision
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Ear aches
- ❑ Nose bleeds
- ❑ Sinus problems
- ❑ Teeth problems
- ❑ Grinding teeth
- ❑ Recurrent sore throats
- ❑ Sores on lips or tongue
- ❑ Jaw clicks

Cardiovascular

- ❑ Swelling of feet
- ❑ Low blood pressure
- ❑ Difficulty breathing
- ❑ Irregular heartbeat
- ❑ Chest pain
- ❑ Fainting
- ❑ Dizziness
- ❑ Venous swelling
- ❑ Blood clots
- ❑ Cold hands
- ❑ Swelling of hands
- ❑ Cold feet
- ❑ Other problems with heart or blood vessels:
- ❑ ____________________

Respiratory

- ❑ Cough
- ❑ Coughing blood
- ❑ Pain with deep breath
- ❑ Difficulty lying down
- ❑ Phlegm color:
- ❑ Other:

Musculoskeletal

- ❑ Neck pain
- ❑ Back pain
- ❑ Shoulder pain
- ❑ Hand/wrist pain
- ❑ Hip pain
- ❑ Knee pain
- ❑ Foot/ankle pain
- ❑ Other muscle pain
- ❑ Muscle weakness
- ❑ Other:

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Gas
- ❑ Belching
- ❑ Indigestion
- ❑ Bad breath
- ❑ Blood in stools
- ❑ Black stools
- ❑ Abdominal pain/cramps
- ❑ Chronic laxative use
- ❑ Other problems with stomach or intestines:
- ❑ ____________________

Genito – Urinary

- ❑ Frequent urination
- ❑ Pain on urination
- ❑ Blood in urine
- ❑ Urgency to urinate
- ❑ Unable to hold urine
- ❑ Decrease in flow
- ❑ Kidney stones
- ❑ Impotency
- ❑ Excessive sexual urge
- ❑ Wake up to urinate how often:

Neuropsychological

- ❑ Lack of coordination
- ❑ Easily susceptible to stress
- ❑ Areas of numbness
- ❑ Treated for emotional problems
- ❑ Depression
- ❑ Bad temper
- ❑ Poor memory
- ❑ Anxiety
- ❑ Seizures
- ❑ Concussion
- ❑ Dizziness
- ❑ Loss of balance
- ❑ Other:

-____________________

-____________________

Pregnancy and Gynecology

- ❑ Painful periods
- ❑ Clots
- ❑ Irregular periods
- ❑ Vaginal discharge
- ❑ Vaginal sores
- ❑ Breast lumps
- ❑ Premenstrual symptoms
- ❑ Unusual character (heavy or light)

- ❑ Use birth control
- ❑ *Type:_______How long:* ___
- ❑ No. of pregnancies: ________
- ❑ No. of births: ________
- ❑ No. of premature births: _ ____________________________
- ❑ No. of miscarriages: ________
- ❑ No. of abortions: ________

- ❑ Age at first menses: _ ________________________
- ❑ Date of last menses: _ ________________________
- ❑ Menses duration: _ ________________________
- ❑ Length of full cycle: _ ________________________
- ❑ Date of last PAP: ________

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HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: ____________________

We keep medical records of the health care services we provide for you. You may ask to see and copy your records. You may ask to correct your records. **Your records will be kept confidential unless you give us written permission to release them or we are required to do so by law.**

We will ask you to sign a consent form allowing us to use and disclose your health information for purposes of consultations, payment and health technique operations in this office. You may see your records or get more information about them by contacting our office.

For more information about our privacy practices please inquire with us. By signing below, I acknowledge receipt of the Notice of Privacy Practices.

____ ____________________
Signature of Rogi or Legal Representative Date