Ayurveda Natural Health Center

Midwest's Authentic Ayurvedic Wellness Center

1342 N. Fairfield Rd., Suite B
Beavercreek (Dayton), Ohio 45432
Phone: 937.429.WELL (9355)
Website: www.MidwestAyurveda.com or www.429WELL.com

Client Intake Form

Today's Date: _____

Name: _____ Gender:_____

Address: _____

City/State: _____ Zip code: _____

Daytime phone #: _____ Evening phone #: _____ Cell phone #_____

E-mail Address:____ _____Check to receive periodic (usually monthly) e-mail offers: _

Date of Birth: _____ Place of Birth:_____

Age: _____ Occupation: _____

Marital Status: _____ Name of Spouse/Significant Other: _____

Children's Names and Ages: _____

Whom may we thank for your referral? _____

Primary Health Care Provider: _____

Provider's Address: _____

City/State: _____ Zip code: _____

Telephone #: _____ Extension: _____

Permission to Consult with Primary Provider, if necessary? __No __Yes ___(please initial)

In Case of Emergency, Please Notify:

Name: _____ Telephone #: _____

Relationship: _____

For any of the questions following, if you need additional space, feel free to attach extra pages. Thank you.

What are your goals for this session? _____

_____

Are you under medical/therapeutic treatment? ____No ____Yes

If so, please state the type(s) and for what condition(s): _____

_____

List medications and supplements you are currently taking: _____

_____

_____

Specify any known allergies: _____

Please list (date and description) of any accidents, injuries, or surgeries you have had:

_____

_____

_____

_____

Please also list any traumatic experiences, past or current, and approximately at what age of life they happened (as a reminder, all of the information on this form is kept confidential).

_____

_____

_____

_____

_____

_____

Indicate stress factors (if any) present in your life: _____

_____

What brings you peace and joy? _____

_____

What places do you enjoy? _____

_____

What activities do you enjoy doing, feel you are successful at doing, and feel empowered by doing them: _____

_____

Describe the types and frequency of exercise activities you engage in: _____

_____

_____

Please describe your daily routine here, include approximate time of day, and what you eat and drink (including snacks), what time you arise and go to bed, etc.

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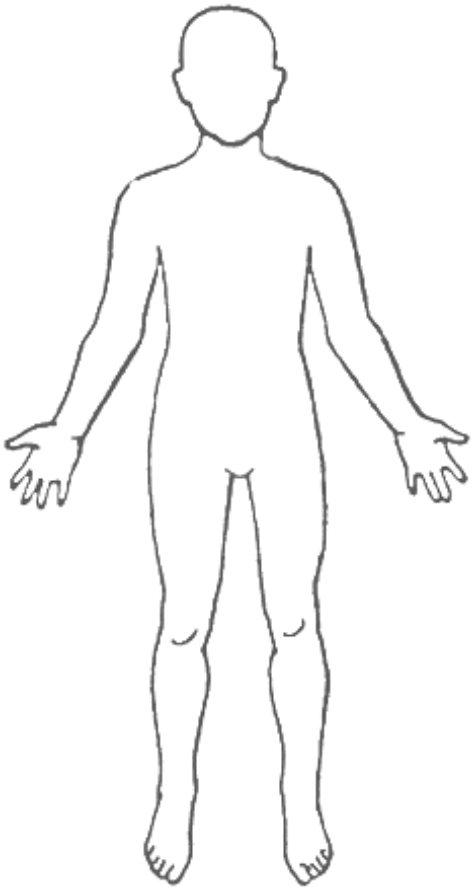
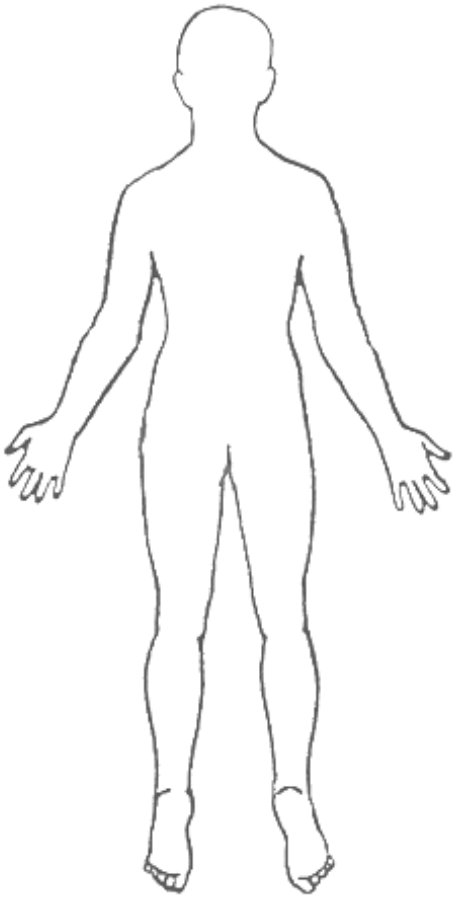
Please mark areas of concern (if any):

Front of body



Back of body



COMMENTS: _____

_____

_____

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Statement of Informed Consent

I understand that the lessons I may receive are intended as personal guidance and education. I seek the opportunity to consider the Practitioner's advice, recognizing that I am free to act upon or disregard his/her recommendations as I choose. I have hereby read, understand, and agree with these statements and attest that I am not currently under the influence of alcohol or other intoxicants. I take full responsibility for my health and wellness.

Signature: _____ Date: _____

Health History

Check the following conditions that apply to you, indicating past or present. Please add your comments to clarify the condition.

Musculo-Skeletal
o Headaches
o Joint stiffness/swelling
o Spasms/cramps
o Broken/fractured bones
o Strains/sprains
o Back, hip pain
o Shoulder, neck, arm, hand pain
o Leg, foot pain
o Chest, ribs, abdominal pain
o Problems walking
o Jaw pain/TMJ
o Tendonitis
o Bursitis
o Arthritis
o Osteoporosis
o Scoliosis
o Bone or joint disease
o Other: _____

Circulatory and Respiratory
o Dizziness
o Shortness of breath
o Fainting
o Cold feet or hands
o Cold sweats
o Swollen ankles
o Pressure sores
o Varicose veins
o Blood clots
o Stroke
o Heart condition
o Allergies
o Sinus problems
o Asthma
o High blood pressure
o Low blood pressure
o Lymph edema
o Other: _____

Skin
o Rashes
o Allergies
o Athlete's Foot
o Warts
o Moles
o Acne
o Cosmetic surgery
o Other: _____

Digestive
o Nervous stomach
o Indigestion
o Constipation
o Intestinal gas/bloating
o Diarrhea
o Diverticulitis
o Irritable bowel syndrome
o Crohn's Disease
o Colitis
o Other: _____

Nervous System
o Numbness/tingling
o Twitching of face
o Fatigue
o Chronic pain
o Sleep disorders
o Ulcers
o Paralysis
o Herpes/shingles
o Cerebral Palsy
o Epilepsy
o Chronic Fatigue Syndrome
o Multiple Sclerosis
o Muscular Dystrophy
o Parkinson's disease
o Spinal cord injury
o
Other:_____

Reproductive System
o Pregnancy:
  o Current
  o Previous – List number___
o PMS
o Menopause
o Pelvic Inflammatory Disease
o Endometriosis
o Hysterectomy
o Fertility concerns
o Prostate problems

Other
o Loss of appetite
o Forgetfulness
o Confusion
o Depression
o Difficulty concentrating
o Alcohol use _____
o Nicotine use _____
o Caffeine use _____
o Hearing impaired
o Visually impaired
o Burning upon urination
o Bladder infection
o Eating disorder
o Diabetes
o Fibromyalgia
o Post/Polio Syndrome
o Cancer
o Infectious disease (please list) _____
o Other congenital or acquired disabilities (please list) _____
o Surgeries _____
o Other:_____

For clients who need mobility assistance, please give your height: _____weight: _____

Please list any additional comments regarding your health and well-being: _____

CANCELLATION POLICY

To provide affordable quality care to our clients, and minimize delays in getting timely appointments, our office has the following policy regarding missed appointments:

Cancellations or rescheduling must be done at least 48 hours in advance of your scheduled appointment, BY PHONE at 429-WELL (9355), or you will be charged the full appointment cost.

Thank you for your cooperation and consideration of our valuable time and yours.

I have read the above policy, and stated all health conditions of which I am aware. This information is true and accurate. I will inform the health care provider of any changes in my status.

Client's Signature: _____ Date: _____