Client Intake Form - Initial Visit

Information provided by client is strictly confidential

Name: _____ Date: _____

Age: _____ Sex: _____ Preferred Gender Pronoun: _____

DOB: _____ Location of Birth: _____

Time of Birth: _____ Do I have permission to look at your birth chart? Y N

Address: _____

Phone: _____ Email: _____

Occupation: _____

How did you hear about services? _____

Emergency Contact: _____ Phone: _____

Current Height and Weight: _____ Weight Goal (if any): _____

Personal Health History

Reason(s) for consult (please include how long you have been experiencing each concern):

_____

_____

_____

What things, if any, have you already tried to address the health concerns you are having?:

_____

_____

_____

What health goals would you like to achieve?

_____

_____

_____

_____

Are you familiar with Ayurveda and what do you hope to gain through services?

_____

_____

_____

_____

In the past 12 months, describe your experience with the following:

Sleep:

_____

__

Energy:

_____

_

Diet:

_____

____

Digestion:

_____

Routine:

_____

_

Mood:

_____

__

Stress:

_____

__

Cravings:
_____

Body:
_____
___

Mind:
_____
___

Emotions:
_____

Skin:
_____
____

Vision:
_____
__

Pain:
_____
____

Inflammation:
_____

Home Life:
_____

Work Life:
_____

Expectations of Yourself:
_____

Expectations of Others:
_____

Relationships:
_____

Menses:
_____

Overall Perception of Self:
_____

Overall Perception of Life:

_____

Anything else you would like to share?

_____

_____

_____

_____

Allergies and/or sensitivities (medicines, foods) Please include the reaction that you experience:

_____

_____

_____

_____

_____

_____

Dietary Preferences (ex: vegetarian, vegan, gluten free, dairy free, etc):

_____

_____

_____

_____

Current Medications, supplements, vitamins, herbs, etc. Please include name, dosage, purpose, and frequency for each:

_____

_____

_____

_____

_____

_____

Surgeries or hospitalizations. Please include approximate date and reason:

_____

_____

_____

_____

Have you had any lab work or blood work done recently? If so, any concerns with your results?

Please describe your childhood experience:

Do you have any religious or spiritual preferences or practices?

Family Health History

Mark "X" for all that apply

Disease/Disorder	Self	Sibling	Mother	Maternal Mother	Maternal Father	Father	Paternal Mother	Paternal Father
Cancer or Tumors								
Diabetes								
Anemia or Blood Disorders								
Seizures, Fainting								
High Blood Pressure								

Disease/Disorder	Self	Sibling	Mother	Maternal Mother	Maternal Father	Father	Paternal Mother	Paternal Father
Low Blood Pressure								
Heart Disease								
Stroke								
Allergies or Asthma								
Chronic Body Pain (back, R/A)								
Substance Abuse								
Depression								
Mental Disorders								
Hepatitis								
Kidney Disorders								
Liver Disorders								
Thyroid Disorders								
Respiratory/Breathing Issues								
Abuse (physical, sexual, emotional)								
Eating Disorders								
Age of Death, if applicable								

Any important family health history that was not addressed above?

_____

_____

_____

_____

Personal Health Habits

Sleep

When do you go to sleep?_____ When do you wake?
_____

Do you have issues going to sleep or staying asleep?
_____

Do you wake in the middle of the night? What time(s)? How often?
_____

Do you feel rested after sleeping? _____ Do you struggle to get out of bed?_____

Do you dream? If so, please typical describe content of dreams:
_____

_____
_____

Diet

What is your relationship to food?
_____

Describe your appetite:
_____

Do you follow a regular eating routine?
_____

Describe your thirst:
_____

What is your favorite thing to eat?
_____

What is your favorite thing to drink?
_____

Breakfast time and foods for the last 3 days:
_____

_____
_____

Lunch time and foods for the last 3 days:
_____

_____
_____

Dinner time and foods for the last 3 days:
_____

_____
_____

Snack time(s) and foods for the past 3 days:
_____

_____
_____

Routine

Morning routine:
_____

Day routine:
_____

Evening routine:
_____

What throws off your routine?
_____

How important is routine to you?
_____

Substances

Do you feel you have an addictive personality? _____ What do you crave most?_____

Do you eat sugar regularly? If so, what and how often?
_____

Do you drink alcohol? If so, what and how often?
_____

Do you smoke tobacco? If so, what and how often?
_____

Do you smoke or ingest marijuana? If so, what and how often?
_____

Do you drink coffee, tea, or caffeinated beverages? If so, what and how often?

_____
_____

Do you use any recreational drugs? If so, what and how often?
_____

Are you interested in help with any of the above substances?
_____

Exercise

Exercise frequency: _____ Types of exercise:
_____

Elimination

How often do you poop? _____ Describe your poop (hard to pass, easy to pass,

urgent, loose, hard, dark, light, complete/incomplete, messy, etc.):
_____

_____
_____

Frequency of urination during the day: _____Do you urinate during the night?
_____

Describe your urine (color, smell, etc):
_____

Do you have difficulty urinating? _____ Pain with urination:
_____

Force in urination decreased: _____ Difficulty emptying bladder:
_____

Have you had a kidney, bladder, or prostate infection in the last 12 months?
_____

Sex

Are you sexually active? _____ Libido (low/med/high):
_____

Contraception Method:
_____

Difficulty experiencing orgasm: _____ Difficulty getting/maintaining an erection:
_____

Vaginal dryness: _____ STD/STI: _____ Other:
_____

Date of last personal wellness exam:
_____

Menstruation

Age at onset of menstruation: _____ Perception of experience:_____

Date of last menstruation: _____ Do you track your cycles?
_____

Regular or Irregular: _____ Period every _____ days. Lasting for _____ days.

Symptoms associated with PMS:
_____

_____
_____

Symptoms associated with menstruation:_____

_____
_____

Symptoms associated with ovulation:
_____

Cysts: _____ Fibroids: _____ Hemorrhoids: _____ Other:
_____

If you could change something about your cycle, what would it be?
_____

_____
_____

Childbirth

Are you pregnant? _____ Have you been pregnant? _____ How many times?
_____

How many live births? _____ Optional additional information:
_____

Describe each pregnancy:
_____

_____
_____

Describe each birth:
_____

_____
_____

_____
_____

How were you cared for after giving birth?
_____

_____
_____

Any complications post pregnancy?
_____

_____
_____

Are you trying to get pregnant currently, or in the next 12 months?
_____

Are you interested in receiving Ayurvedic Doula services?
_____

Menopause

Are you peri or post menopausal? _____ Date of last menses:
_____

Symptoms associated with menopause:
_____

_____
_____

_____
_____

Men's Health

Any sexual difficulty? If yes, please describe:
_____

Testicular pain, inflammation, masses, etc:
_____

Discharge, tenderness, sores, hemorrhoids, etc:
_____

Date of last prostate exam, if applicable:
_____

Additional information:
_____

_____
_____

Optional Additional Information:

From page _____:

_____
_____

_____
_____

_____
_____

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_____

_____
_____

_____
_____