(2) FAMILY HISTORY

Indicate what members of your immediate family have had these conditions. (Go back one generation)
(If adopted, answer according to family heritage, if known.)

❑ High Blood Pressure ________________ ❑ Heart Disease ____________________ ❑ Other ____________

❑ Cancer ____________________________ ❑ Mental Disorder ___________________ ____________________

❑ Stroke _____________________________ ❑ Diabetes _________________________ ____________________

(3) ALCOHOL, TOBACCO AND SUBSTANCE USE

	PRACTITIONER NOTES:
a. Do you drink alcoholic beverages? ❑ Yes ❑ No If yes, how often: ❑ *Daily* ❑ *Several times weekly* ❑ *Several times monthly* ❑ *Seldom* I usually choose: ❑ beer ❑ wine ❑ sweet or hard liquor	
b. Have you ever smoked tobacco? ❑ Yes ❑ No If yes, how much per day?___________ If you have quit smoking, when did you quit? ____	
c. Any current or past use of addictive or habitual substances? ❑ Yes ❑ No ***(Note: This will be kept confidential)*** Please list all substances (either current or long-term past usage):______________________ ____ ____	

(4) REGULAR PRACTICES

❑ EXERCISE/HATHA YOGA *(Specify)*	❑ *None/Never*	❑ *Occasional* ❑ *Daily*	❑ *Several times per week* ❑ *Several times per month*
❑ TEAM SPORTS/RECREATION *(Specify)*	❑ *None/Never*	❑ *Occasional* ❑ *Daily*	❑ *Several times per week* ❑ *Several times per month*
❑ TRAVEL *(Include commute if applicable)*	❑ *None/Never*	❑ *Occasional* ❑ *Daily*	❑ *Several times per week* ❑ *Several times per month*
❑ SPIRITUAL PRACTICES *(Specify)*	❑ *None/Never*	❑ *Occasional* ❑ *Daily*	❑ *Several times per week* ❑ *Several times per month*
❑ MEDITATION/PRAYER/PRANAYAMA *(Specify)*	❑ *None/Never*	❑ *Occasional* ❑ *Daily*	❑ *Several times per week* ❑ *Several times per month*
❑ OTHER *(Include creative activities)*	❑ *None/Never*	❑ *Occasional* ❑ *Daily*	❑ *Several times per week* ❑ *Several times per month*

(5) SEXUAL ACTIVITY

According to Ayurveda, a person's level of sexual activity impacts health and well-being in the same way as other aspects of daily life--such as diet or sleep.

a. How often do you engage in sexual activity (include sex with partner and masturbation):

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

b. Is your current sexual activity satisfactory? ❑ *Yes* ❑ *No*

*PATIENT NAME:*____

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(6) FOOD CHOICES

What types of foods do you eat on a regular basis?

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

(7) DAILY LIQUID INTAKE *(Indicate number of 8 ounce cups per day)*

- ❑ Plain water ________________
- ❑ Caffeinated Coffee/Tea _________
- ❑ Herbal Tea or Juice___________
- ❑ Cow or Goat Milk ___________
- ❑ Decaffeinated Coffee/Tea _______
- ❑ Soda or soda pop ____________
- ❑ Grain/nut/soy milk ___________

(8) HABITUAL EATING PATTERNS

Describe any current or past eating patterns or any other food related issues.

(9) DAILY SCHEDULE *(include approximate times)*

What are your habitual activities from the time you wake up until you go to sleep? Include mealtimes, sleeping, exercise, work, and any activities that occur on a regular basis.

		TIME	HABITUAL ACTIVITIES	INTERN NOTES
MORNING	Awaken			
	Mealtime			
	Activities			
DAY	Mealtime			
	Activities			
NIGHT	Mealtime			
	Activities			
	Bed-time			

(10) ALLERGIES OR SENSITIVITIES

Do you have allergic reactions to any substances (including food, pollens, medicines)? If yes, please list.

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(11) CHALLENGING PATTERNS

Please indicate any physical and emotional patterns that *you find challenging* by assigning a ***Frequency*** (a number from 1 to 3) and ***Intensity*** (a number from 1 to 10):

FREQUENCY	INTENSITY
1 = DAILY	1 TO 3 = MILD DISCOMFORT
2 = SEVERAL TIMES WEEKLY	4 TO 6 = MODERATE DISCOMFORT
3 = SEVERAL TIMES MONTHLY	7 TO 10 = SEVERE DISCOMFORT

A. DIGESTION

	Frequency 1-3	Intensity 1-10
Excessive gas		
Excessive belching		
Acid reflux		
Burning indigestion		
Nausea or vomiting		
Sleepy after eating		
Heaviness after eating		
Bloated after eating		

B. ELIMINATION

	Frequency 1-3	Intensity 1-10
Constipation (less than 1 BM/day)		
Alternating constipation & diarrhea		
Food particles in stool		
Diarrhea		
Rectal pain or hemorrhoids		
Blood in stool		
Mucus in stool		
Abdominal pain		

C. EMOTIONS

	Frequency 1-3	Intensity 1-10
Worry		
Anxiety		
Overwhelm		
Self-destructiveness		
Anger		
Resentment		
Critical/Blaming		
Intense		
Lethargic		
Melancholy		
Depression		
Stubbornness		

(12) ADDITIONAL SYMPTOMS OF CONCERN

	Frequency 1-3	Intensity 1-10

(13) PREVIOUSLY DIAGNOSED CURRENT CONDITIONS

PRACTITIONER NOTES
Please describe symptoms of diagnosed condition

*PATIENT NAME:*______________________________

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