AYURVEDA

CONSULTATION

Ayurvedic Patient Consultation

Please fill in this form (where relevant) and email it back to me by the day of your appointment. Please bring any relevant health records with you on the day. All information given strictly is confidential.

Date _____

VIKRUTI - IMBALANCE	PRAKRUTI - BALANCED
V P K	V P K

Personal Details

Name _____

Age _____

Occupation _____

Relationship status _____

Email + Phone _____

Concerns and Objectives

Please list any issues you would like this consultation to address, albeit physical, emotional, mental or spiritual.

ISSUE	Symtpom/Duration

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Have there been any recent changes or conerns in the following areas:

VATA	PITTA	KAPHA	AMA	GENERAL
❍ dryness ❍ insomnia ❍ gas ❍ bloating ❍ constipation ❍ hemorroids ❍ muscle: twitching cramping, numbness weakness ❍ joint pain ❍ stiffness ❍ shifting, tearing pain ❍ dry cough ❍ cold extremities ❍ dry skin ❍ restlessness ❍ fear, worry, anxiety	❍ diarrhea ❍ loose stool allergies ❍ nausea ❍ migraines ❍ vomiting ❍ skin rash, acne ❍ bruising ❍ excess thirst ❍ burning pain ❍ spontaneous bleeding ❍ tender to touch ❍ excess body heat ❍ interrupted sleep ❍ anger, rage, envy, critical, judgement	❍ congestion ❍ food/respiratory ❍ edema ❍ heaviness ❍ dullness burning or difficult ❍ dull, vague pain ❍ cold, clammy hands ❍ difficulty sweating ❍ frequent urination ❍ excess oily skin ❍ excess sleep ❍ depression, greed, ❍ attachment ❍ mental lethargy	❍ coating on tongue ❍ low grade fever ❍ excess sleep ❍ malaise ❍ lethargy ❍ lack of energy ❍ lack of appetite ❍ sinking stool ❍ pregnancy ❍ other/OBGYN	❍ energy level ❍ throat/eye/ears ❍ chest/lung/heart ❍ agni (appetite/digestion) ❍ urine: clear, cloudy ❍ nails ❍ menses ❍ menopause

Genetic History

Please list any hereditary conditions

Father

Mother

Grandparents

Siblings

Self

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Health History

Please list past serious illnesses / allergies/ accidents and any treatment received

ISSUE	Symptoms/Duration/Treatment received

Current medication taken for?

Current supplements taken for?

Current complimentary therapies used?

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Digestive Health

Is your appetite:	(feeling of hunger) Please choose one of the following and add additional comments : Erratic (sometimes very hungry, other times not) Sluggish Excessive Balanced
Do you suffer from any of these?	Flatulence/ bloating Heartburn Bad breath Irritable Bowel Syndrome Gallstones/ Liver problems Undigested food in stool an unpleasant taste in your mouth
Any food intolerances or sensitivities?	
What is your typical diet/ foods taken regularly?	Breakfast Lunch Supper
How much raw food do you eat (% of total)	
How much meat/fish do you eat (%)	
How much dairy do you eat (%)	
Are meal times regular?	
What snacks are eaten and when?	
Glasses of water/ herbal tea per day	
Amount of black tea, coffee or alcohol, drugs, cigarettes?	

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Elimination

No. of bowel movements/ day

Do you get constipation or diarrhoea?

Any of the following in regards to your stool?

Sinks Mucus Floats Bad odour No odour Sticky Undigested food seen

Any issues with urine?

Immunity/Activity

How is your immunity?

How many colds/ flu per year?

Do you suffer from (please give details): Cold sores Thrush Candida Hay fever Allergies

How are your energy levels? Balanced Erratic Feel tired a lot Chronic fatigue

How active are you, including exercise taken?

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Metabolism

Do you generally feel warm or cold?

Do you feel pain anywhere?

Do you sweat easily?

Are you often thirsty?

Psychological

Are you stressed/ worried? What is the cause?

How is your self-esteem?

How are your relationships?

Can you express your feelings?

Are you happy in your work?

Sleep

When do you go to bed and wake up?

Any insomnia? What time?

Do you feel rested on waking in the morning?

How many hours sleep needed?

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Women

Are your periods regular?

How many days do they last?

Do you suffer from:
Use of Contraception current/ in past:

Pregnancy history/ children:

Age of menopause (if relevant)

Have you ever suffered from:
Fibroids Endometriosis Yeast infection Irregular bleeding Infertility

Appearance

Weight/ Height

Do you have dry skin, hair, nails?

Any skin problems
Psoriasis Eczema Rashes Acne Other: