Nicola Turner Ayurveda

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Intake Form

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Intake Form

Please fill out

Name: _____

Address: _____

Phone: _____

Email Address: _____ How did you come to me?: _____

Birthdate: _____ # of Children: _____

Age: _____ Weight: _____

Marital Status: _____ Height: _____

Occupation: _____ For how long?

On a scale of 1-10, with 10 being high and 1 being low,
how stressed do you feel each day

_____

Main purpose of visit:

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Have you had unintentional weight loss or gain of 10 pounds or more, in the last 3 months?

_____

Are you taking any medications? If so, what is the name, what is it used for and for how long?

_____ for _____

_____ for _____

_____ for _____

_____ for _____

Please list any major hospitalizations, injuries, surgeries. illnesses, and/or accidents:

Procedure & Year: _____ **Outcome:** _____

Procedure & Year: _____ **Outcome:** _____

Procedure & Year: _____ **Outcome:** _____

Procedure & Year: _____ **Outcome:** _____

Procedure & Year: _____ **Outcome:** _____

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Please share some of your family history and detail ailments applicable (eg. type of cancer)

	Age of death	Cancer	Diabetes	Headaches	Heart Disease	Other
Mother:						
Father:						
Maternal Grandparent:						
Maternal Grandparent:						
Paternal Grandparent:						
Paternal Grandparent:						
Sibling:						
Sibling:						
Sibling:						
Sibling:						

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Please list current complaints in order of severity:

1 _____ **For how long?** _____

2 _____ **For how long?** _____

3 _____ **For how long?** _____

4 _____ **For how long?** _____

Please share some of the symptoms you are experience and type "X" for all that apply:

	Headaches		Dizziness
	Neck Pain		Shortness of Breath
	Stiffness		Sleeping Problems
	Sensations of Pins and Needles		Digestive Problems
	Itching and/or Rashy		Lightheaded
	Numbness		Back Pain
	Disinterest in Sex		Vomiting
	Irritability		Depression
	Chest Pain		Incontinence

Do you wear:

	Corrective Lenses		Dentures		Hearing Aid
	Medical Devices / Prosthetics / Implants	Describe: _____			

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Would you like to:

- [ ] Have more energy
- [ ] Be stronger
- [ ] Have more endurance
- [ ] Improve digestion
- [ ] Have less stress
- [ ] Increase your sex drive
- [ ] Be thinner
- [ ] Be more muscular
- [ ] Improve your complexion
- [ ] Have stronger nails
- [ ] Have healthier hair
- [ ] Be less moody and/or depressed
- [ ] Be less indecisive
- [ ] Feel more motivated
- [ ] Be more organized
- [ ] Think more clearly and be more focused
- [ ] Improve memory
- [ ] Do better on tests in school
- [ ] Stop using laxatives or stool softeners
- [ ] Be free of pain
- [ ] Sleep better
- [ ] Have agreeable breath and/or stronger teeth
- [ ] Have agreeable body odor
- [ ] Get fewer colds and flus
- [ ] Get rid of your allergies
- [ ] Reduce the risk of inheritable diseases
- [ ] Lessen dependence on over the counter medications like aspirin, tylenol, benadryl, sleeping aids, etc.

Are you taking any supplements:

- [ ] Multivitamin/mineral
- [ ] Vitamin C
- [ ] Vitamin E
- [ ] Vitamin B Complex
- [ ] Vitamin D
- [ ] EPA/DHA
- [ ] Evening Primrose/GLA
- [ ] Calcium, source: _____
- [ ] Magnesium
- [ ] Zinc
- [ ] Minerals:_____
- [ ] Friendly flora (acidophilus)
- [ ] Digestive enzymes
- [ ] Amino acids
- [ ] CoQ10
- [ ] Antioxidants (e.g., lutein, resveratrol, etc.)
- [ ] Herbs – teas
- [ ] Herbs – extract
- [ ] Chinese herbs:_____
- [ ] Ayurvedic herbs: _____
- [ ] Homeopathy
- [ ] Bach flowers
- [ ] Protein shakes
- [ ] Superfoods (bee pollen, phytonutrient blends)
- [ ] Liquid meals (e.g., Ensure): _____
- [ ] Other:_____

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Habit	Serving Amount	Consumed Per Day
Smoking Cigarettes /Cigars (Nicotine):	1 cigarette	
Smoking Marijuana:	1 joint	
Drinking Liquor:	1 shot (1.5 oz.)	
Drinking Wine:	1 glass (5 oz.)	
Drinking Beer:	1 pint (12 oz.)	
Drinking Coffee (with Caffeine):	1 cup (8 oz.)	
Drinking Tea (with Caffeine):	1 cup (8 oz.)	
Drinking Soda :	1 cup (8 oz.)	
Drinking Water:	1 cup (8 oz.)	
Other: _____	_____	_____

Exercise or Activity	Duration (Minutes)	Per Week
Walking:		
Hiking:		
Biking:		
Running:		
Swimming:		
Dancing/Pilates:		
Other Cardio:		
Weight Lifting:		
Yoga:		
Flexibility / Stretching:		
Other Sports, Fitness, and Training:		

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Mark "X" for the time of day you feel most energized and/or least amount of symptoms.

	7am - 9am		3pm - 5pm		11pm - 1am
	9am - 11am		5pm - 7pm		1am - 3am
	11am - 1pm		7pm - 9pm		3am - 5am
	1pm - 3pm		9pm - 11pm		5am - 7am

Mark "X" for the time of day you feel least energized and/or symptoms are aggravated.

	7am - 9am		3pm - 5pm		11pm - 1am
	9am - 11am		5pm - 7pm		1am - 3am
	11am - 1pm		7pm - 9pm		3am - 5am
	1pm - 3pm		9pm - 11pm		5am - 7am

Share some brief information about your sleeping behavior.

What is your bedtime? _____ Do you fall asleep quickly? _____ Do you dream? _____

What are your dreams about? _____

Do you wake up at night? _____ How often? _____ What time? _____

What time do you rise? _____ How do you feel upon waking up? _____

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Foods you eat:

Favorite Foods:

Do you eat meat: _____ What kind: _____ How often: _____

Do you eat dairy: _____ What kind: _____ How often: _____

Mark with an "X" special food allergies and/or restrictions.

_____ Dairy _____ Wheat _____ Soy

_____ Eggs _____ Corn _____ Gluten

_____ Other (describe): _____ _____

Meal schedule: Please describe time, foods eaten or meals skipped.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

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Please list your health issues as a child.

1 _____ Age? For how long? _____

2 _____ Age? For how long? _____

3 _____ Age? For how long? _____

Evacuation or elimination of bowel movements.

Time of day: _____

Frequency: _____ Consistency: _____ Floats / Sinks: _____

Color: _____ Odor: _____ Mucus: _____

Burning/Straining: _____ Hemorrhoids: _____ Gas: _____

Evacuation or elimination of urine.

Frequency: _____ Color: _____ Odor: _____

Relief at night: _____ UTI / Bacterial / Yeast History: _____

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For females only.

First day of last period: _____ Duration (# of days): _____

PMS symptoms / Cramps: _____ Duration: _____

Describe any irregularities? _____

How many pregnancies? _____ How many kids? _____

Any delivery difficulties? _____

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How are your relationships with:

Family: _____

Friends: _____

Partner: _____

Colleagues: _____

Discovering your passions.

What are your passions? _____

What are your hobbies? _____

How often do you live them? _____

Have you lost any? _____

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Religion/Spirituality

Are you spiritual/religious person? _____

Do you have a spiritual practice? _____

Would you like one? _____