AYUR WELLNESS & SPA

AYURVEDIC HEALTH COUNSELOR - PATIENT INTAKE

25564 Barton Road Loma Linda, CA 92354 Phone: (909 844-2677)

Name:

Address: City: State: Zip:

Telephone—Home: Cell: Work:

Birthdate: Age: E-mail:

Occupation:

Marital/partner status: # of children: Ages:

Emergenc y Contact Name Number:

How did you hear about the California College of Ayurveda Intern Program?

Please tell us why you have chosen to have an Ayurvedic Consultation:

WHAT YOU CAN EXPECT FROM YOUR AYURVEDIC HEALTH CARE

Ayurveda is a natural healing system practiced for thousands of years, originating in ancient India. It recognizes that each person's path to health is unique, based on an individual body–mind constitution.

At Ayur Wellness and Spa, our programs are grounded in authentic Ayurvedic principles, focusing on identifying imbalances and creating personalized wellness plans through thoughtful consultation. Your program may include lifestyle and dietary guidance, herbal support, and holistic therapies such as aromatherapy, sound therapy, and massage. With regular follow-ups, our goal is to support natural healing, restore balance, and enhance your body's innate ability to heal itself.

Patient's Signature: Date:

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INFORMED CONSENT

All patients who participate in Ayurvedic health care through this program should be advised of the following information:

1. The California College of Ayurveda is not a medical college.
2. Intern Ayurvedic Health Counselors (AHC) studying with the California College of Ayurveda (CCA) are not trained in Western diagnosis or treatment and may not make suggestions about altering your medical care.
3. In the State of California, Ayurveda is a non-licensed profession. Neither the California College of Ayurveda nor the services offered by any Ayurvedic practitioner, intern practitioner or therapist employed, contracted or a student of, is licensed. The practice of Ayurveda as an alternative or complementary service which formally legalized under the passage of Senate Bill 577 in January 2003.
4. If you are suffering from a disease or symptom that has not been evaluated by a medical doctor or another licensed healthcare professional, we recommend that you receive a proper evaluation and may provide you with a referral form. If your Intern AHC refers you to a medical doctor, you will be required to follow through with that referral or sign an acknowledgment that you refused the referral.
5. Neither your Intern AHC nor anyone in association with the college/healthcare center may recommend altering your prescriptions without the approval of your medical doctor. Your Intern AHC may suggest that you speak to your doctor about reducing medication when he/she feels that it is appropriate.
6. While your Intern AHC may take your blood pressure, vital signs and perform some examination techniques similar to a routine medical examination, the findings will be evaluated from an Ayurvedic perspective only and not from a Western medical perspective. This examination does not take the place of a medical evaluation. If, as a result of the examination any findings suggestive of a possible medical imbalance is found, your Intern AHC will refer you to a medical doctor for further evaluation.
7. Ayurveda is a complementary and alternative healthcare system. Care from your practitioner may be utilized as a complement to your current health care program.
8. By signing below, you give your permission to use the information in your chart for research purposes. (NOTE: patient names, addresses, phone numbers, or email addresses are not included in the research records.)

I have read and understand the above disclosure regarding Ayurvedic treatments and practitioner education. I acknowledge that Ayurvedic practitioners are not licensed physicians and that these services are not state-licensed. I understand it is my responsibility to maintain care with a medical doctor for myself or my child. I voluntarily consent to receive Ayurvedic services and agree to be personally responsible for all associated fees.

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CONFIDENTIAL PATIENT HISTORY

FINANCIAL POLICY AGREEMENT

1. There is a $____ charge for each initial consultation with an Ayurvedic Health Counselor (AHC) . This includes the Report of Findings meeting which occurs within 10 days of the initial visit.
2. There is a $____ charge for each follow-up visit with an AHC Intern.
3. Your customized program often incorporates herbal formulas. There is a charge for herbs, preparation and shipping (if needed). Your AHC intern will order all herbal formulas on your behalf.
4. The college does not bill insurance companies for services or herbs.
5. All online appointments must be booked with a credit card and will be charged following the appointment.
6. If you are not seeing your AHC Practitioner Intern at the CCA campus, payment for all consultations and herbs must be made to them using their preferred method of billing.
7. If Panchakarma or spa services are recommended and provided at the CCA Ayurvedic Spa, payment for those services is made directly to CCA.
8. If you fail to show for your appointment without notice, or you cancel within 24 hours of your appointment, a $____ fee will be charged to your account. This includes online and phone appointments.

Patient's Signature: Date:

FOR INTERN USE ONLY:

Intern Name: Initial Appointment: ROF Date:

(1)PAST MEDICAL HISTORY

Please list any major condition(s)and dates of diagnosis, treatment, and procedures performed.

a. Are you under the care of a licensed health care professional or any other healthcare provider? ☐ Yes ☐ No

If so, for what reasons: _____

b. Serious illnesses: _____

_____

c. Hospitalizations: _____

d.Operations: _____

e. List other pertinent current or past conditions: _____

_____

f. Have you had any cosmetic surgery or procedures performed? ☐ Yes ☐ No

If so, please list: _____

g. Are you pregnant? ☐ Yes ☐ No ☐ N/A

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(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:_____

☐ Cancer:_____ ☐ Mental Disorder:_____

☐ Stroke:_____ ☐ Diabetes:_____

☐ Other:_____

(3)ALCOHOL, TOBACCO AND SUBSTANCE USE

a.Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, how often: ☐ Daily ☐ Several times weekly ☐ Several times monthly ☐ Seldom How many glasses?_____

PRACTITIONER NOTES:_____

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 tobacco, what year did you quit?_____

Do you smoke marijuana? ☐ Yes ☐ No If yes, how much per day?_____

PRACTITIONER NOTES:_____

c.Any current or past use of other addictive or habitual substances? ☐ Yes ☐ No

(Note: This will be kept confidential)

Please list all substances (either current or long term past usage):_____

_____

PRACTITIONER NOTES:_____

(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

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(5) RELATIONSHIP

a. Please indicate how nourished you feel in your relationship (1 being the least nourished, 10 being the most nourished): _____

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

c. Is your current sexual activity satisfactory? ☐ Yes ☐ No

Practitioner Notes: _____

(6)FOOD CHOICES (Please be as detailed as possible)

What percentage of your food is organic? _____

List below what types of foods you eat on a regular basis.

Breakfast:	
Lunch:	
Dinner:	
Snacks:	

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

☐ Caffeinated Coffee/Tea:	☐ Herbal Tea or Juice:	☐ Decaffeinated Coffee/Tea:	☐ Soda or Diet Soda:
☐ Plain water:	☐ Cow or Goat Milk:	☐ Grain/Nut/Soy Milk:	

(8)HABITUAL EATING PATTERNS

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

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(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.

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

(10)ALLERGIES OR SENSITIVITIES

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

(11)AYURVEDIC HISTORY

For each category please identify your tendency over time by placing an "X" in the box that is most appropriate for you. If you are unsure or would like to speak to your practitioner about this please check (√) in the column to the right. (Practitioners: V = short term tendencies / Vikruti, P = Long-term tendencies / Prakruti)

CATEGORY				PRACTITIONER USE ONLY (FREQUENCY / INTENSITY 1-10)
Appetite	☐ I prefer to eat frequently but my hunger level is variable, and I often forget to eat. Practitioner use only ☐ V ☐ P	☐ I have a strong appetite I prefer to eat 3x/day and rarely skip meals. Practitioner use only ☐ V ☐ P	☐ I prefer to eat 2-3x/day, but I can go without eating with no discomfort. Practitioner use only ☐ V ☐ P	☐
Appetite	☐ If I miss a meal, I often get light-headed, anxious or cranky. Practitioner use only ☐ V ☐ P	☐ If I miss a meal, I often get critical or angry. Practitioner use only ☐ V ☐ P	☐ If I miss a meal, it doesn't really bother me. Practitioner use only ☐ V ☐ P	☐
Digestion	☐ After eating, I often experience gas or bloating Practitioner use only ☐ V ☐ P	☐ After eating, I often experience heartburn or acidity. Practitioner use only ☐ V ☐ P	☐ After eating, I often feel heavy or sleepy. Practitioner use only ☐ V ☐ P	☐

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Elimination	☐ I tend to have irregular bowel movements one time per day or less. Practitioner use only ☐ V ☐ P	☐ I tend to have 1 or more bowel movements daily, usually with regularity and ease. Practitioner use only ☐ V ☐ P	☐ I tend to have one bowel movement per day with no straining or difficulty. Practitioner use only ☐ V ☐ P	☐
Elimination	☐ My bowel movements are often dry and hard. At times I may strain or push. Practitioner use only ☐ V ☐ P	☐ My bowel movements are usually well-formed, but sometimes they are loose and may burn. Practitioner use only ☐ V ☐ P	☐ My bowel movements are usually well-formed, slow and easy. Practitioner use only ☐ V ☐ P	☐
Weight	☐ I usually don't gain weight very easily. Practitioner use only ☐ V ☐ P	☐ When I gain weight, it is easy to lose it. Practitioner use only ☐ V ☐ P	☐ I gain weight easily and lose it slowly. Practitioner use only ☐ V ☐ P	☐
Body Temperature	☐ My hands and feet often feel cold, and I prefer warmer climates. Practitioner use only ☐ V ☐ P	☐ I am warm most of the time no matter what the climate is. Practitioner use only ☐ V ☐ P	☐ I adapt easily to most conditions, but tend to feel cool. Practitioner use only ☐ V ☐ P	☐
Sleep	☐ I tend to sleep lightly and awaken very easily. It can be difficult for me to go to sleep. Practitioner use only ☐ V ☐ P	☐ I tend to sleep soundly and awaken with ease. Practitioner use only ☐ V ☐ P	☐ My sleep tends to be deep and long. It can be difficult for me to awaken in the morning. Practitioner use only ☐ V ☐ P	☐

MENTAL & EMOTIONAL PATTERNS

CATEGORY				PRACTITIONER USE ONLY
Stress	☐ Under stress I often become worried or overwhelmed. Practitioner use only ☐ V ☐ P	☐ Under stress I often become irritable, but usually rise to the challenge. Practitioner use only ☐ V ☐ P	☐ Under stress, I often withdraw to observe or become reclusive. Practitioner use only ☐ V ☐ P	☐
Decision Making	☐ I am changeable and often have difficulty making decisions. Practitioner use only ☐ V ☐ P	☐ I make decisions easily, but can change my mind with new information. Practitioner use only ☐ V ☐ P	☐ I am careful but easy-going about decisions. Practitioner use only ☐ V ☐ P	☐
Projects	☐ I like to start projects, but at times have difficulty finishing them. Practitioner use only ☐ V ☐ P	☐ I like to start and finish projects. Completion is important to me. Practitioner use only ☐ V ☐ P	☐ I like working on a project, but prefer to let others start them. Practitioner use only ☐ V ☐ P	☐
Personality	☐ When I am balanced I feel creative, enthusiastic, and vivacious. Practitioner use only ☐ V ☐ P	☐ When I am balanced I feel perceptive, disciplined, and logical. Practitioner use only ☐ V ☐ P	☐ When I am balanced I feel nurturing, calm, and de votional. Practitioner use only ☐ V ☐ P	☐

PRACTITIONER USE ONLY:

V PRAKRUTI:	P PRAKRUTI:	K PRAKRUTI:
V VIKRUTI:	P VIKRUTI:	K VIKRUTI:

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(12)CHALLENGING PATTERNS

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

INTENSITY	Patient Example:
1 TO 3 = MILD DISCOMFORT	Acid Reflux
4 TO 6 = MODERATE DISCOMFORT	Frequency 3x wk
7 TO 10 = SEVERE DISCOMFORT	Intensity 4

A. DIGESTION	Frequency Number of times per week, month or year	Intensity 1-10
Excessive Gas		
Excessive belching		
Acid reflux		
Burning indigestion		
Nausea or vomiting		
Sleepy after eating		
Heaviness after eating		
Bloated after eating		

	Frequency Number of times per week, month or year	Intensity 1-10
Constipation (less than1 BM/day)		
Alternating constipation & diarrhea		
Food particles in stool		
Diarrhea		
Rectal pain or hemorrhoids		
Mucus in stool		
Abdominal pain		

C. EMOTIONS	Frequency Number of times per week, month or year	Intensity 1-10
Worry		
Anxiety		
Overwhelm		
Anger		
Resentment		
Critical/Blaming		
Intense		
Lethargic		
Melancholy		
Depression		
Stubbornness		

ENERGY LEVELS

Describe your energy levels on a scale of 1 to 10:_____ (1 being 'great' to 10 being 'completely exhausted')

Patient Notes:

PRACTITIONER USE ONLY:

Vikruti: Add up Doshic symptoms that are daily or have an intensity of 4 and higher.

V VIKRUTI:	P VIKRUTI:	K VIKRUTI:

☐ Additional Notes See (ROF 5)

PATIENT NAME: