The Healing Gardens of Ayurveda Wellness Center
250 El Camino Real, Suite 201
Tustin CA. 92780
714-730-7919

Confidential Client History

Name: _____

Address: _____

City, State, Zip: _____

Telephone: Home:_____Work:_____Cell:_____

Email:_____ Birth date :_____Age:_____

Marital Status: _____ No. of Children: _____ Occupation: _____

Is there any possibility that you are pregnant? [] Yes [] No [] Possible

Are you nursing? [] Yes [] No

Family Physician: _____

How did you hear about The Healing Gardens of Ayurveda? [] Website [] Newspaper ad. [] Referral [] Other

Objectives

Please check the items that reflect your main Objectives:

[] I want an alternative approach to allopathic medicine for managing illness and disease
[] I want to improve my general health and wellness and reduce my vulnerability to illness and disease
[] I want to improve my lifestyle and dietary practices to improve my health
[] I want to change my habits and behavioral patterns to improve my relationships with others
[] I want to manage stress, tension and worry to attain a more stable emotional nature

What do you want to achieve or change in terms of your health and wellness?

How would your life be different if you were to achieve these objectives to your satisfaction:

_____

Review of Concerns

List your chief complaint and any other significant symptoms that you are concerned about. If you have been diagnosed with any disease or condition, list these as well.

Chief Complaint: _____

Diagnosed Conditions:

_____

Please check the digestive, elimination and emotional challenges that you experience. There are very important from an Ayurvedic perspective. Please indicate your current condition by (C) and general tendencies by (G) in each category.

Digestion

[] abdominal Pain	[] Burning Indigestion	[] Nausea/Vomiting
[] Excessive Gas	[] Heartburn	[] Sluggish after eating
[] Belching	[] Smelly Gas	[] Sleepy after eating
[] Bloating	[] Other:	[] Other:

Elimination

[] Constipation/Irregular	[] Regular/Soft Stool Diarrhea	[] Regular/Oily/Mucus in Stool

Psychology

[] Worry/Anxiety	[] Irritable/Anger	[] Lethargy/Slow Pace
[] Fear	[] Rage	[] Depression
[] Spaceyness	[] Jealousy/Envy	[] Over Attachment
[] Insomnia/light sleep	[] Moderate Sleep (6-8hrs)	[] Heavy sleep (8-10 hrs)
[] Indecisive/Quick in making decisions But changeable	[] Decisive and focused	[] Slow in making decisions but steady
[] Flying or fearful dreams	[] Violent, fiery Dreams	[] Romantic, watery dreams, swimming

Comments regarding symptoms listed above:

General Health and Lifestyle Patterns

1. *Do you exercise regularly*? [] yes [] no Length of time: _____times per week: _____
2. *How much of the following do you drink*? (Note: 1 cup = 8 ounces)
   Water No. of cups per day: _____
   Non-caffeinated beverages: No. of cups per day: _____ types : Herbal tea/milk/juice/other _____
   Caffeinated beverages: No. of cups per day: _____ types: Coffee/tea/soda _____
   Alcohol: No. of cups per : day/week/month (please circle).
3. *Do you currently smoke*?
   [] Yes- How may cigarettes per day? _____how long have you smoked ?_____
   [] No – Have you ever smoked? [] yes [] no. If yes, when did you quit _____
4. *Any current or past use of addictive substances*? [] yes [] no [] quit, when? _____
5. *Do you experience allergic reaction to any substance*s (food, environmental etc.) Please explain:_____
6. *What type of work do you do*: _____
7. *Please circle your work level of stress* – (1 = least, 5= most): 1 2 3 4 5 Level of satisfaction: 1 2 3 4 5
8. *Are you currently experiencing stress in any close relationship*? If yes, level of emotional stress 1 2 3 4 5
9. *Are you sexually active*? [] yes [] no
10. *Do you have any specific spiritual practices*? Please describe _____

Dietary Patterns

What kind of taste do you prefer? Please check one of the following:
1. Sweet/Sour/Salty []
2. Sweet, Bitter, Astringent []
3. Pungent, Bitter, Astringent []

Any current or past chronic eating disorders or other food related issues? [] yes [] no

Please indicate your primary food choices and meal times:

Meals	**Time(s)**	**Typical foods and Beverages**
Breakfast:		
Lunch:		
Dinner:		
Snacks:		

Current Medications, Herbs or Supplements

What medications are you currently taking or have taken recently, including birth control and hormone replacement therapy?

_____
_____
_____

Have you noticed any significant changes?

_____
_____

Are you currently taking any Herbal Remedies or Supplements? Please list.

_____
_____
_____

For Women Only

Menstrual History Please check:

Your period is/was [] Heavy [] Light Period
Cycle [] 28 days [] 30 days [] other, please describe:

Menopause:

Do you have any pre/post menopausal symptoms? Please describe:

Medical History

Personal History:

Do you or your parents (indicate by P) have a history of: (check ailments that apply)

Allergies to foods or drugs	[] yes [] no	Heart surgery	[] yes [] no
Anemia	[] yes [] no	Hepatitis A	[] yes [] no
Arthritis	[] yes [] no	Hepatitis B	[] yes [] no
Asthma, Pneumonia, TB	[] yes [] no	Hepatitis Non-A/Non B	[] yes [] no
Blood Pressure, high/low	[] yes [] no	HIV Exposure	[] yes [] no
Cancer	[] yes [] no	Frequent attacks of colds /coughs	[] yes [] no
Chronic Constipation	[] yes [] no	Chronic Diarrhea	[] yes [] no
Chemotherapy/ Radiation	[] yes [] no	Kidney or Bladder disease	[] yes [] no
Chest Pain	[] yes [] no	Mental Disorder	[] yes [] no
Cholesterol, elevated	[] yes [] no	Jaundice, Gallstone	[] yes [] no
Dental complications	[] yes [] no	Ear pain or ringing	[] yes [] no
Diabetes	[] yes [] no	Jaw pops, clicks or locks	[] yes [] no
Dizziness	[] yes [] no	Prolonged bleeding when cut	[] yes [] no
Epilepsy, convulsions, seizures	[] yes [] no	Rheumatic Fever	[] yes [] no
Fainting	[] yes [] no	Sinusitis	[] yes [] no
Feet or ankle swelling	[] yes [] no	Shortness of Breath	[] yes [] no
Glaucoma, eye surgery	[] yes [] no	Stroke	[] yes [] no
Heart Attack	[] yes [] no	Thyroid disease	[] yes [] no
Heart disease/ Heart murmur	[] yes [] no	Ulcers, Intestinal bleeding	[] yes [] no
Implant/Prosthesis	[] yes [] no	Venereal Diseases	[] yes [] no

Please explain any items checked:

_____

_____

Any Other Disease or Problems not listed above:

_____

_____

Have you been under the care of a licensed health care practitioner in the past year? [] yes [] no, if so for what reasons:

_____

_____

Date of last physical exam : _____

Any past history of:

[] serious injuries
[] Trauma
[] Emotional/Mental stresses
[] Troubled lifestyle conditions
[] Changes in weight
[] Aches, pains
[] stress
[] Fatigue
[] Mental Clarity/Concentration
[] Vision problems, including dry eyes
[] Hot flashes
[] Cosmetic surgery

Please describe any items checked:_____

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INFORMED CONSENT TO RECEIVE COMPLEMENTARY OR ALTERNATIVE HEALTH CARE

All clients who participate in Ayurvedic Health Care should be advised of the following information:

1. Ayurveda is the traditional healing system from India, and is based on the idea that each person's path toward optimal health is unique. Your program is based on an understanding your unique constitution and the unique nature of your imbalance. Your program may include lifestyle adjustments, dietary changes, herbs, yoga and meditation, Ayurvedic therapies, aromatherapy and therapeutic massages. The goal of all programs is to create within your body and mind an optimum environment for healing to take place and to maximize your body's ability to heal itself.
2. The Healing Gardens of Ayurveda, LLC is not a medical facility.
3. Employees of The Healing Gardens of Ayurveda LLC are not trained in Western diagnosis or treatment and may not make suggestions about altering your medical care unless a California Certified Medical Doctor on staff is consulted.
4. The National Institute of Health Office of Complementary and Alternative Medicine currently considers Ayurveda a form of complementary and alternative medicine in the United States. In the State of California, Ayurveda is a non-licensed profession. Its practice was formally legalized under the passage of Senate Bill 577 in January 2003. Ayurvedic Consultations are considered alternative or complementary to healing arts that are licensed by the State of California.
5. If you are suffering from a disease or symptom that has not been evaluated by a Medical Doctor or another licensed health care professional, we recommend that you receive a proper evaluation and may provide you with a referral form. If you are referred to a medical Doctor, you will be required to go or sign an acknowledgement that one was recommended to you.
6. No one in association with The Healing Gardens of Ayurveda LLC may recommend altering your prescriptions without the approval of your medical doctor. Your Practitioner may suggest that you speak to your doctor about reducing medications when he/she feels that it is appropriate.
7. While your Practitioner may take your blood pressure and vital signs, and perform some examination techniques similar to a routine medical examination, your Practitioner is evaluation their findings 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 this examination, any finding suggestive of a possible medical condition is found, your Practitioner will refer you to a Medical Doctor for further evaluation.
8. The following services Not offered by The Healing Gardens of Ayurveda LLC unless under direct supervision of medical doctor:
    - Diagnosis, Treatment or advice of pathological conditions
    - Prescription drugs or medicine

I have read and understand the above information and give my permission to begin a program of Ayurvedic Health care with The Healing Gardens of Ayurveda LLC

Clients Signature: _____ Date: _____