Ayurveda Herbal Wellness Center

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Client History

Name: _____ **Date:** _____
Address: _____
City/State/Zip: _____
Phone Number: _____ **DATE OF BIRTH:** _____
Recommended By: _____ **email:** _____

Reason for Consultation: _____
_____
_____

What are your symptoms?

#1: _____
How Long have you had them? _____
#2: _____
How Long have you had them? _____
#3: _____
How Long have you had them? _____
#4: _____
How Long have you had them? _____
#5: _____
How Long have you had them? _____
#6: _____
How Long have you had them? _____

Occupation _____ **Do you enjoy your work?** _____
Rate level of job stress _____ **Source of job stress** _____
Do you experience stress in any particular part of your body? _____

Married _____ **Single** ____ **Divorced** _____
How many children at home? _____ **Pregnancies** _____ __

How do you feel about your current relationship status? _____
If in a relationship, are your happy? _____
Family life stresses _____

Medical History

What major illnesses or operations have you had in your life?

_____

_____
_____
_____
_____

Have you had a medical exam in the past year? _____
Results of exam?
_____

Are you on any medication? ___No ___Yes Which Ones:_____

Have you consistently experienced any of the following:

___ Abdominal Pain
___ Allergies
___ Arthritis
___ Asthma: -Childhood or
-Adult onset
___ Blurred Vision
___ Circulatory Problems
___ Constipation
-When _____
___ Diarrhea
___ Digestive Problems
-When _____
___ Headaches
___ Fatigue / Exhaustion
Why _____
___ High / Low Blood Pressure
___ Insomnia
When _____

___ Low Blood Pressure ____
___ Menstrual Regularity _____
___ Migraines: When _____
_____
How often _____
___ Miscarriage
___ PMS -Symptoms: _____
_____
___ Respiratory Probems _____
Do you experience: Congestion, dryness, phlegm & where in body_____
_____
___ Sinus Infections
___ Skin Problems
What kind _____
___ Stomach Ulcers
___ Varicose Veins

General Health Information

<u>Do you have a healthy diet:</u> ___ Always ___ Most of the time ___ Sometimes ___ Never
<u>Exercise:</u> ___Once per day ___Once per week ___More than 1 x week ___Seldom ___Never
What types of exercise: _____

Family History

Illnesses from your Father's side of family:
_____
Illnesses from your Mother's side of family:
_____ _____