Initial Questionnaire

Date: _____

Personal Data:

Name: _____

Address: _____

City or Town: _____

State: _____ Zip Code: _____

Country: _____

E-mail address: _____

Telephone (home): _____

Telephone (work):_____

Telephone (cell):_____

Fax number: _____

Gender: □ Male □ Female

Age_____ Birth date: _____

Marital Status: Married Single Divorced Widowed

Occupation: _____

Are you ALLERGIC to, or intolerant of, any HERBS, SPICES, FOODS or DRUGS? Please list below:

What are your goals for your wellness consultation today?

Do you currently engage in any activities that could compromise your health or would be considered "unhealthy"?

Do you have any current health concerns or problems?

Any significant previous health concerns or problems?

Any significant family history of health problems?

Please list all prescription medications, birth control pills, hormone replacement therapy, vitamins or other supplements that you are taking:

Please list foods you typically eat for:

Breakfast:

Lunch:

Dinner:

Snacks:

Any special dietary needs?

Previous Ayurvedic evaluations and treatments:

List date and place of most recent previous Ayurvedic evaluation, if any:

_____

List date and place of most recent in-residence Ayurvedic programs, if any:

_____

Body Weight: _____

Height: ____ ft. ____ in. Weight: Now _____ , 1 year ago _____
Maximum_____ When? _____ Minimum _____ When? _____
Any weight gain or loss in the past 6 months? (# of pounds, + or -)_____

Digestion: _____

1. Is your digestion: □ Good □ Fair □ Poor
2. Is your appetite: □ Strong □ Moderate □ Mild □ Variable
3. In general, how is your energy during the day? □ Strong □ Medium □ Low □ Variable
4. Do you often feel heavy after eating? □ Yes □ No
5. Do you often feel sleepy after eating? □ Yes □ No
6. Do you have problems with (please circle):
   Gas flatulence belching bloating heartburn acid indigestion reflux
   Other:
7. Are there any foods that cause discomfort? _____

Elimination:

1. Do your bowel movements tend to be?
   □ Regular □ Irregular
2. How often do you have bowel movements?
   □ More than 3 times a day □ 2-3 times per day
   □ Once daily □ Less than once every 3 days
3. When do you usually have bowel movements?
   □ First thing in the morning
   □ Later in the morning
   □ In the afternoon □ Immediately after meals
   □ At night after dinner
4. Stools are usually:
   □ Soft □ Medium □ Hard □ Variable consistency
5. Do you use enemas or laxatives?
   □ No □ Yes How often? _____
6. Do you have hemorrhoids?
   □ No □ Yes If yes, do they bleed? _____

Diet and Eating Behavior: _____

1. Is your diet:
   □Non-vegetarian □Mostly Vegetarian □Vegetarian
2. Which is your main meal?
   □ Breakfast □ Lunch □ Dinner
3. Do you eat between meals? □ Yes □ No
4. How much time do you take for: Breakfast _____ Lunch_____ Dinner_____
5. Do you sit for 5-10 minutes after finishing a meal (circle one)? □ Yes □ No
6. Do you feel you now have or had in the past an eating disorder? □ Yes □ No

7. How often do you eat the following?
    a. Leftovers? □ Often □ Sometimes □ Rarely □ Almost never
    b. Frozen foods? □ Often □ Sometimes □ Rarely □ Almost never
    c. Packaged/processed foods? Leftovers? □ Often □ Sometimes □ Rarely □ Almost never

    d. Cold foods and/or drinks? □ Often □ Sometimes □ Rarely □ Almost never
    e. Raw vegetables (salad)? □ Often □ Sometimes □ Rarely □ Almost never
    f. Red meat? □ Often □ Sometimes □ Rarely □ Almost never
    g. Spicy foods? □ Often □ Sometimes □ Rarely □ Almost never

8. How many times per week do you eat out in a restaurant? _____
9. How often do you microwave your food or drinks? □ Often □ Sometimes □ Rarely □ Almost never
10. About what percentage of your food is organically grown? _____
11. How many soft drinks or diet soft drinks do you drink each week? _____
12. What kind of water do you drink? _____

Sleep:_____

1. Is your sleep disturbed?
    □ Not at all □ Somewhat □ Moderately
    □ Severely □ Very Severely
2. **Do you take sleep aids? _____**
3. **What time do you usually go to bed (lights out)?_____**
4. **What time do you usually wake up?_____**
5. **Are your bedtime and arising times regular from day to day?**
    □ Very Regular □ Mostly regular □ Somewhat regular □ Mostly irregular

Daily Routine: _____

1. How regular is your daily routine (for example, do you go to bed, get up, and eat your meals around the same time daily)?
    □ Very regular □ Not very regular
    □ Somewhat regular □ Very irregular
2. Do you go to bed early (by 10:00-10:30 p.m.)? □ Yes □ No
3. Do you get up early (by 6:00-6:30 a.m.)? □ Yes □ No
4. Do you eat your meals on time? □ Yes □ No
5. How often do you exercise?
    □ Regularly □ Occasionally □ Never
6. What type of exercise do you do, if any? _____
7. Is your exercise?
    □ Vigorous □ Moderate □ Light □ None

8. Do you practice meditation? □ Yes □ No
    a. How often? □ Regularly □ Occasionally □ Never
    b. What kind?_____

9. Do you take daytime naps? □ Often □ Sometimes □ Rarely □ Almost never
10. Do you travel a lot? □ Yes □ No
11. **How often do you:**
    a. **Smoke: _____**
    b. **Drink alcohol: _____**
    c. **Drink caffeinated beverages: _____**

12. **Do you feel you take enough time for yourself? □ Yes □ No**
13. **How many hours per day do you use a computer? _____**
14. **How many minutes per day on a cell phone? _____**
15. **Are you having work or family problems that are impacting your health? □ Yes □ No**
16. Do you perform "cleansings"? □ Yes □ No Describe: _____

Psychology _____

1. How would you describe your mood? _____
2. Do you suffer from? (circle relevant) anxiety, depression, anger, mood swings
3. Are you currently in psychological counseling? □ Yes □ No

Section for Women _____

Menstrual History:
Age of onset: _____
Date of last period: _____
Date of last GYN exam: _____ Any abnormalities? □ Yes □ No
(If yes, describe)_____
Do you take birth control pills? □ Yes □ No
Length of time taking: _____

1. Which of the following describes your menstruation? (Choose as many as apply)
   □ Regular □ Absent □ Irregular □ Too frequent
   □ Infrequent □ Ceased due to menopause

(If you are post-menopause, please skip to Question 5)

2. How many days does your menstrual period last?
   □ Zero to four days □ Five to seven days
   □ More than seven days □ Spotty/irregular

3. Is your menstrual flow?
   □ Heavy □ Light □ Normal

4. Associated symptoms (before or during Menstruation):
   □ None □ Fluid retention □ Pain □ Acne Other_____

5. Do you have any discharge outside of your menstrual period?
   □ Yes □ No

6. Do you have any itching of vaginal area?
   □ Yes □ No

7. Pregnancies:
   Are you pregnant now? □ Yes □ No □ Don't know
   Number of children:_____
   Number of pregnancies: _____
   Describe any complications with pregnancy:
   _____