Ayurveda New Client Form

Name_____ **Date**_____

Date of Birth_____ **Age** _____ **Phone number**_____

Current Concerns or Wellness Goals Explain in detail

_____

_____

_____

_____

Medical History Current and past medical concerns

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Surgeries Procedure, date, and any complications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Medications Name of medication, dose, and frequency of use

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Supplements Over the counter vitamins, minerals, and herbs

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Family Medical History

	Still Alive?	Age	Medical Problems
Father	yes no		_____
Mother	yes no		_____
Sibling	yes no		_____
Sibling	yes no		_____
Sibling	yes no		_____
Child	yes no		_____
Child	yes no		_____
Child	yes no		_____
Additional	yes no		_____

Social History

Single___ Married___ Divorced___ Partner/significant other___ Widowed ___

Number of children_____ Number of children living at home_____

Tobacco use per day currently_____ Former smoker_____ Chewing tobacco_____

Years of tobacco use_____ Year quit_____

Alcohol use per week_____ Caffeine_____ Soda_____

Exercise_____

_____

Dietary Information

Typical breakfast _____

Typical lunch _____

Typical dinner _____

Snacks _____

Toxic Exposure (asbestos, mercury, lead, solvents, chemicals, etc) Yes No

If yes, what?_____

Sleep Excellent Good Poor Terrible

Work History

Current _____

Past _____

_____

Family of Origin Where you grew up, what your family was like, etc.

_____

_____

_____

Personal Traumatic Events Abuse, significant deaths, accidents, etc.

_____

_____

_____

Spiritual History

_____

_____

_____