Ayurvedic Intake Questionnaire

Date: Name.....Signature.....

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced

Age:..... Height: ..... Weight: Past…… Current…… Occupation: .....

Date of birth: ..... Time of birth ..... Place of birth .....

Address: .....State..... Zip .....

Phone: ..... E-mail :.....

Why are you interested in an Ayurvedic consultation?……..

Please describe your present health problems and their <u>duration</u>?

1.....

2.....

3.....

4.....

5.....

6.....

7.....

8.....

9……

10……

How long have you had the chronic conditions about which you are consulting?

☐ Less than 6 months ☐ 6 months to 2 years ☐ 2 to 5 years ☐ More than 5 years

How has your health problem progressed since it began?

☐ Stable ☐ Gradually improving ☐ Rapidly improving ☐ Fluctuating
☐ Gradually worsening ☐ Rapidly worsening

Please explain the overall intensity of your symptoms?
☐ Very severe ☐ Severe ☐ Moderate ☐ Mild

Is your sleep disturbed by the symptoms?
☐ Not at all ☐ Some what ☐ Moderately ☐ Severely ☐ Very severely

To what extent are you having any degree of bodily pain or discomfort?

☐ Not at all ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

How often are you having pain or discomfort?

☐ Daily ☐ Less than once a week ☐ Several times per week ☐ Several times a day ☐ Most or all the time

How long does the pain or discomfort last on the average?

☐ No pain ☐ 10-15 minutes or less ☐ About 30 minutes ☐ About one hour ☐ More than one hour ☐ Most of the day

Are you currently under the care of family physician or any other health professional?

☐ Yes ☐ No If yes, mention details .....……..

What is their opinion about your health?

☐ Easily cured ☐ Difficult to cure ☐ Incurable ☐ Did not say

Have you undergone any investigations for blood, urine, stools, x-ray, ultra-sound, MRI etc?
If yes, please specify in detail.....

Are you currently taking any medications and/or receiving any medical treatment for your health condition?
If so, please list all medications/treatments and their dosage:

Do you have any past medical history? If yes, please specify the age of occurrence, duration and its treatment.

Is there a family history of this health problem?

☐ Yes ☐ No If yes, please specify .....

Concern	**Father**	**Mother**	**Brothers**	**Sisters**	**Spouse**	**Child**	**Other**
Age (if living)							
Age (at death)							
Cause of death							
Anemia							
Cancer							
Diabetes							
Epilepsy							
Glaucoma							
Heart disease							
High blood pressure							
Hay fever							
Hives							
Kidney disease							
Mental disease							
Rheumatic arthritis							
Tuberculosis							
Syphilis							
Stroke							
Others							

How severe are your symptoms?

☐ Very severe ☐ severe ☐ moderate ☐ Mild

Are you allergic to any substances? Please specify: food, pollen, dust etc., and any other allergic reactions?

Health as a child: ☐ Good ☐ Fair ☐ Poor

Childhood illnesses:

☐ Scarlet Fever ☐ German measles ☐ Measles ☐ Mumps ☐ Bronchial problems
☐ Rheumatic fever ☐ Diphtheria ☐ Other ……..

Immunizations / Vaccinations:

☐ Smallpox ☐ Polio ☐ Typhoid ☐ Mumps ☐ Tetanus ☐ Influenza ☐ Others ……

Any Vaccination Reaction:……..

How would you rate your usual energy level?

☐ Very high ☐ High ☐ Moderate ☐ Low ☐ Very low

Describe your bowel movements?

☐ Once every 2-3 days ☐ Once daily ☐ 2-3 times per day
☐ First thing in the morning ☐ Late in daytime ☐ Immediately after meals
☐ Immediately after dinner ☐ Need laxative daily ☐ Other, please specify .....

Bowel nature: ☐ Soft ☐ Medium ☐ Hard

Bowel movement associated with: ☐ Pain ☐ Gas ☐ Blood ☐ Mucous ☐ Foul smell ☐ Other …….

Do you have any of the following urinary problems?

☐ Pain ☐ Burning sensation ☐ Discoloration ☐ Other discharges ☐ Frequent urination during the day
☐ Urination several times during the night ☐ Urine retention ☐ Others ……

Do you delay or suppress any of the following?
☐ Bowel movements ☐ Gas ☐ Urination ☐ Sleep ☐ Yawning ☐ Burping
☐ Breathing ☐ Sneezing ☐ Hunger ☐ Thirst ☐ Semen ☐ Cry, tears

Do you practice any type of meditation? Please explain.

Do you practice any Yoga techniques? Please explain.

What is your present state of mind and emotions? ☐ Good ☐ Fair ☐ Poor

Do you often experience any of the following?

☐ Worry ☐ Anxiety ☐ Fear or panic ☐ Loneliness
☐ Depression ☐ High stress level ☐ Lack of memory ☐ Light-headedness
☐ Lack of energy ☐ Suicidal tendency ☐ Anger ☐ Irritation

Do you get up early? ☐ Yes ☐ No At what time.....

Do you go to bed early? ☐ Yes ☐ No At what time.....

Do you sleep in the daytime? ☐ Yes ☐ No

How do you generally feel on arising in the morning?

☐ Fresh and rested ☐ Little tired ☐ Moderately tired ☐ Fairly tired

How is your sleep?

☐ Sound, normal duration ☐ Light, interrupted ☐ Too little sleep
☐ Too heavy and or too long ☐ Difficulty falling asleep ☐ Difficulty waking up
☐ Awaken too early ☐ Frequently nightmares

To what direction does your head point during sleep?

☐ East ☐ West ☐ North ☐ South
☐ Northeast ☐ Northwest ☐ Southwest ☐ Southeast

What is your sleeping position?

☐ On back ☐ On tummy ☐ Left side ☐ Right side ☐ Other, please specify.....

How regular is your daily routine (for example, do you go to bed early, eat your meals on time, exercise regularly etc?)

☐ Very regular ☐ Somewhat regular ☐ Irregular

What is your body build? ☐ Thin ☐ Large ☐ Average ☐ Muscular

Are you overweight? ☐ Yes ☐ No If so, by how much?

☐ Less than 15 pounds ☐ 15-30 pounds ☐ 30-50 pounds ☐ More about 50 pounds

Do you travel a lot? ☐ Yes ☐ No

How often do you exercise?

☐ Weekly once ☐ Weekly twice ☐ Weekly thrice ☐ Weekly four times ☐ Every day ☐ Not at all

How long do you exercise? .....…..What type of exercise? ……

Is your exercise: (choose one) ☐ Vigorous ☐ Moderate ☐ Light Type of exercise:.....

Do you smoke cigarettes or others? ☐ Yes ☐ No

If yes, how many per day? ½ pack / 1 pack / 2 packs / more than 2 packs

How often do you drink alcohol?

Never / less than once a week / about once a week / several times a week / More than once a day
How much:.....

How often do you drink caffeinated (coffee, tea etc) beverages? Never / one cup daily / 2 – 3 cups daily / 4 – 5 cups daily

Which type of weather makes you feel most uncomfortable? (Choose one) ☐ Cold ☐ Hot ☐ Cool and damp

DO YOU EAT THE FOLLOWING FOOD GROUPS

Food groups	Daily	Weekly	Monthly	Never
Grains / Cereals				
Vegetables				
Fruits				
Dairy				
Eggs				
Poultry				
Meat				
Seafood				
Sugar / Honey				
Desserts				
Juices				
Other				

Please explain your typical food habit?

Breakfast: .....

Lunch: .....

Dinner: .....

Snacks: .....

Do you eat between meals? ☐ Yes ☐ No

Do you eat your meals on time? ☐ Yes ☐ No

Which is your main meal? ☐ Breakfast ☐ Lunch ☐ Dinner

Rate your digestion: ☐ Good ☐ Fair ☐ Poor

How much water you drink per day? Never / 1-2 glasses / 3-4 glasses / 5-6 glasses / 7 glasses and more

My eating habits include:

☐ Eat with full attention on food ☐ Talk or converse a lot while eating ☐ Eat very fast
☐ Watch television while eating ☐ Never sit to eat

Describe your diet: ☐ Vegan ☐ Lacto-vegetarian ☐ Ova-lacto-vegetarian ☐ Others please specify .....

Non-vegetarian:

☐ Beef ☐ Pork ☐ Chicken ☐ Turkey ☐ Seafood ☐ Eggs ☐ Others please specify .....

Have you experienced any changes in your sense of taste? (Choose one)

☐ Loss of taste ☐ Sweet taste in mouth ☐ Sour taste in mouth ☐ Bitter taste in mouth
☐ Pungent taste in mouth ☐ Not specific

What taste(s) do you like or crave? ☐ Sweet ☐ Salty ☐ Bitter ☐ Sour ☐ Hot/Spicy ☐ Starches ☐ Oily

Are there any particular foods that create discomfort when you eat them?
☐ Sweet ☐ Sour ☐ Oily or fatty ☐ Hot ☐ Salty ☐ Bitter ☐ Astringent ☐ Dairy products (including cheese)

How are your family relationships? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How is your social life? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How is your mental status? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How is your career? ☐ Love it ☐ like it ☐ can stand it ☐ cannot stand it

How purposeful is your life? ☐ Completely ☐ somewhat ☐ neutral ☐ not happy

Rate your spiritual life: ☐ Fully satisfying ☐ somewhat satisfying ☐ neutral ☐ empty

As a child, did you experience any abuse or trauma? ☐ None ☐ Emotional ☐ physical ☐ Sexual ☐ Verbal
☐ Other, please explain .....……

For Men only:
Do you have any problems?

☐ Hernias ☐ Testicular masses ☐ Sexually active ☐ Sexual difficulties ☐ Prostate problems ☐ Venereal disease
☐ Discharge or sores ☐ Problem starting urination ☐ Problem stopping urination
☐ Libido ☐ Erection problems ☐ Tenderness, enlargement of breast ☐ Birth control

For Women only:
Age menses began: ……..

Which of the following describes your menstruation? (You may choose more than one)

☐ Regular ☐ Irregular ☐ Too frequent ☐ Absent ☐ Ceased due to menopause

How many days does your menstrual period last?

☐ Zero to four days ☐ Five to seven days ☐ More than seven days ☐ Spotty irregularly throughout the month

☐ Others, please explain.....……

How is your menstrual flow? ☐ Heavy ☐ Light ☐ Normal ☐ Abnormal vaginal discharges

Associated symptoms (before or during menstruation):

☐ None ☐ Pain ☐ Fluid retention ☐ Migraine ☐ Depression
☐ Acne ☐ Tension ☐ Anger ☐ Frustration ☐ Loneliness
☐ Nightmares ☐Suicidal tendency ☐ Other, please specify .....……..

Do you have any discharge outside of your menstrual period? ☐ Yes ☐ No

Do you experience pain during intercourse? ☐ Yes ☐ No

Do you have any sexual difficulties? ☐ Yes ☐ No
If yes, please explain ……..

Are you pregnant now? ☐ Yes ☐ No ☐ Don't know

Do you take contraceptive pills or other devices? ☐ Yes ☐ No If yes, Please explain……..

Number of previous pregnancies (choose one) 0 / 1 / 2 / 3 / 4 / 5 / 6 / 7 or more

Do you have any history of abortion, miscarriage, etc? If yes, explain.....……

How many children do you have? ..... Children's ages: .....…….

Do you self-exam breasts regularly? …….

Do you experience any problems in breasts? ☐ Lumps ☐ Pain or tenderness ☐ Nipple discharge ☐ Others ……

How to determine your constitution

When answering these questions, go as far back as you can remember, to your youth and early adult years. You want to identify those characteristics that you were born with. This will help in identifying your constitution. Generally pick one per category (though in some there may be more than one) and circle, then add up your score at the bottom.

Mental Profile

	Vata		**Pitta**		**Kapha**	
Mental activity	Quick,,active, restless		Sharp, critical, aggressive		Calm, steady, slow, stable	
Memory	Short term		Generally good		Good long term	
Concentration	Weak		Generally good		Very good	
Ability to learn	Quick to grasp concepts		Moderate ability to grasp new information		Slow to grasp new information	
Dreams	Fearful, very active, flying,		Aggressive, fiery, adventurous		Watery, romance, relationships	
Sleep	Light, interrupted		Sound, medium		Sound, heavy, long	
Speech	Quick, can miss words		Sharp, direct, strong		Slower, clear, melodious	
Voice	High pitched		Medium pitched		Low pitched	
Sub-total						

Behavioral Profile

	Vata		**Pitta**		**Kapha**	
Eating Speed	Fast		Medium		Slow	
Hunger level	Irregular		Sharp, can be strong		Can easily miss meals	
Food/Drink	Prefers warm		Prefers cold		Prefers dry and warm	
Achieving goals	Easily distracted		Focused and driven		Slow and steady	
Giving/donations	Gives small amounts		Gives nothing or large amounts infrequently		Gives regularly and generaously	
Relationships	Many casual		Intense		Long and deep	
Sex drive	Variable, low		Moderate		Strong	
Works best	Supervised		Alone		In groups	
Weather preference	Warm and moist		Cool and dry		Warm and dry	
Reaction to stress	Excites quickly		Medium		Slow to get excited	
Financial	Doesn't save, spends quickly		Saves but big spender		Saves regularly, accumulates wealth	
Routine	Dislikes routine		Likes planning and organizing		Works well with routine	
Sub-total						

Emotional Profile

	Vata		Pitta		Kapha	
Moods	**Changes quickly**		**Changes slowly**		**Steady, unchanging**	
Reacts to stress with	Fear		Anger		Indifference	
More sensitive to	Own feelings		Not sensitive		Others feelings	
When threatened tends to	Run		Fight		Make peace	
Relations with spouse/partner	Clingy		Jealous		Secure	
Expresses affections	With words		With gifts		With touch	
When feeling hurt	Cries		Argues		Withdraws	
Emotional trauma causes	Anxiety		Denial		Depression	
Confidence level	Timid		Outwardly self confident		Inner confidence	
Sub-total						

Physical Profile

	Vata		**Pitta**		**Kapha**	
Amount of hair	Average		Thinning		Thick	
Hair type	Dry, frizzy, thin, dark		Straight, fine, premature graying		Oily, wavy, thick	
Hair color	Light brown, blond		Auburn, reddish		Dark brown, black	
Skin	Dry, rough or both, dark/sallow, tans easily, cold		Soft, normal to oily, light, sunburns easily, warm		Oily, moist, fair, thic, cool	
Complexion	Darker		Pink, red		Pale-White	
Eyes	Small, brown, gray, violet, unusual color		Medium, Green, hazel, almond-shaped		Large, dark, blue	
Whites of eyes	Blue/brown		Yellow or red		Glossy/white	
Teeth	Very large or very small		Small -medium		Medium-large	
Weight	Thin, hard to gain		Medium		Heavy, easy to gain	
Elimination	Dry, hard, thin, easily constipated		Many during day, soft to normal		Heavy, slow, thick, regular	
Sweat	Scanty		Profuse		Moderate	
Sub-total						

TOTAL	**Vata**		**Pitta**		**Kapha**	