Eternal Breath
Nirvana

Ayurvedic Consultation Intake Questionnaire

Name_____Date_____

Age _____ Height_____ Male / Female Married / Single / Divorced

Weight_____ Weight (past) _____ Occupation_____

Date of birth _____Time of birth_____ Place of birth_____

Address_____State_____Zip_____

Phones (home, cell, work)_____

Email_____

1. Why are you interested in an Ayurvedic consultation?

2. Please describe your present health concerns, which you would like help with

Health Concern	Start Date	Mild / Moderate / Severe	Attempted treatment & Response

3. Do you take any nonprescription drugs or vitamins or any other supplement Please list all of the them:

Name	Start Date	Dosage/Frequency

4. Are you currently under the care of family physician or any other health professional? If yes, mention details:

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

Medication/Treatments	Start Date	End Date

6. Do you have any past medical history or problem? (any other illness ,trauma, emotional stress addictions drug abuse or anything else to help us clearly understand your health condition)

Disease	Start Date	End Date	Treatment – drug, exercise, etc.

7. Family History – *Fill only the positive yes as "Y" or a check mark.*

	Father	Mother	Brother(s)	Sister(s)	PGM	PGF	MGM	MGF
Diabetes								
Hypertension								
Heart Disease								
Stroke								
Asthma								
Cancer								
Hypothyroid								
Hyperthyroid								
Arthritis								
Other								
If not living, age of and cause of death								

PGM = Paternal Grandmother; PGF = Paternal Grandfather; MGM = Maternal Grandmother; MGF = Maternal Grandfather

8. Have you had any kind of surgery or minor procedures performed?

Procedure	Date

9. Please list any hospitalizations

Year	Condition	Procedure Done

Daily Routine

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

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

12. Do you sleep in the daytime? □ Yes □ No

13. How do you generally feel on arising in the morning?

□ Fresh and rested □ A little tired □ Moderately tired □ Fairly tired

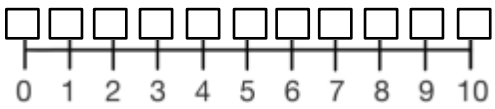
14. Describe your physical activity:

Activity	**Intensity**	**Hours**	**Days/ week**	**Start date**
How often do you break a sweat with exercise? (times/week)				
How many hours do you watch TV every week?				
Do you watch TV, read or surf while eating meals?				

Eating Habits

15. On a scale of 0 to 10, how hungry do you feel at different times of the day?

0 – not at all 1-3 – mildly hungry 4-7 moderately hungry, 8-9 – quite hungry 10 – very hungry!



	Example	Morning	Mid-morning	Lunch	Snack	Evening	Dinner	Bedtime
Time	11am							
How hungry	8 am							

16. Please indicate what food types you eat and their frequency.

Food groups	Daily	Weekly	Monthly	Never
Grains/ Cereals				
Vegetables				
Fruits				
Dairy				
Eggs				
Poultry				
Meat				

Seafood				
Sugar/ Honey				
Desserts				
Juices				
Other				

17. Please explain your typical food habits:

Breakfast	
Lunch	
Dinner	
Snack(s)	

18. Do you eat between meals? □ Yes □ No
19. Do you eat your meals on time: □ Yes □ No
20. Which is your main meal? □ Breakfast □ Lunch □ Dinner
21. Rate your digestion: □ Good □ Fair □ Fair

Personal preference

22. Which weather do you prefer? Warm / cool/ both
23. Which extreme of weather are you unable to tolerate? Hot / Cold / Neither
24. Which taste do you prefer? Sweet/ Sour/ Salty/ Hot/ Bitter/ Astringent
25. How thirsty do you feel? Often/ Moderate/ Not much
26. Do you sweat easily? Often/ Not that much/ rarely

Have you experienced any of the following in the past 3 months?

General

- ☐ Poor appetite
- ☐ Cravings
- ☐ Change in appetite
- ☐ Peculiar tastes/smells
- ☐ Strong thirst – hot
- ☐ Strong thirst – cold
- ☐ Weight gain
- ☐ Weight loss
- ☐ Poor sleep
- ☐ Fatigue
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Fevers
- ☐ Chills
- ☐ Tremors
- ☐ Poor balance
- ☐ Localized weakness
- ☐ Bleed/bruise easily
- ☐ Sudden energy drop

Time(s) of day:

Skin & Hair

- ☐ Rashes
- ☐ Skin tags
- ☐ Itching
- ☐ Change in skin/hair texture
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Loss of hair
- ☐ Dandruff
- ☐ Other:

Head

- ☐ Dizziness
- ☐ Facial pain
- ☐ Migraines
- ☐ Headaches
- ☐ Other:

Eyes, Ears, Nose & Throat

- ☐ Glasses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Eye strain
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Color blindness
- ☐ Eye pain
- ☐ Spots in vision
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Earaches
- ☐ Nose bleeds
- ☐ Sinus problems
- ☐ Teeth problems
- ☐ Grinding teeth
- ☐ Recurrent sore throats
- ☐ Sore on lips or tongue
- ☐ Jaw clicks

Cardiovascular

- ☐ Swelling of feet
- ☐ Low blood pressure
- ☐ Difficulty breathing
- ☐ Irregular heartbeat
- ☐ Chest pain
- ☐ Fainting
- ☐ Dizziness
- ☐ Venous swelling
- ☐ Blood clots
- ☐ Cold hands
- ☐ Swelling of hands
- ☐ Cold feet

Respiratory

- ☐ Cough
- ☐ Coughing blood
- ☐ Pain with deep breath
- ☐ Difficulty lying down
- ☐ Phlegm color:
- ☐ Other:

Musculoskeletal

- ☐ Neck pain
- ☐ Back pain
- ☐ Shoulder pain
- ☐ Hand/wrist pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Other muscle pain
- ☐ Muscle weakness

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Indigestion
- ☐ Bad breath
- ☐ Blood in stools
- ☐ Black stools
- ☐ Abdominal pain/cramps
- ☐ Chronic laxative use
- ☐ Other:

Genito - Urinary

- ☐ Frequent urination
- ☐ Pain on urination
- ☐ Blood in urine
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Decrease in flow
- ☐ Kidney stones
- ☐ Impotency
- ☐ Excessive sexual urge
- ☐ Do you wake up to urinate often? How often?

Neuropsychological

- ☐ Easily susceptible to stress
- ☐ Areas of numbness
- ☐ Treated for emotional problems
- ☐ Lack of coordination
- ☐ Depression
- ☐ Bad Temper
- ☐ Poor Memory
- ☐ Anxiety
- ☐ Seizures
- ☐ Concussion
- ☐ Dizziness
- ☐ Loss of balance
- ☐ Other

Pregnancy & Gynecology (Women Only)

- ☐ Painful periods
- ☐ Clots
- ☐ Irregular periods
- ☐ Vaginal discharge
- ☐ Vaginal sores
- ☐ Breast lumps
- ☐ Premenstrual symptoms
- ☐ Use of Birth Control
- ☐ Unusual character (heavy or light)

Eternal Breath
Nirvana

Name:_____ Date: _____

Welcome to Eternal Breath Nirvana. Our practitioners of Ayurveda are not licensed physicians, and Ayurveda services are not state-licensed. Ayurveda, a 5000-year-old wisdom of healthy living, focuses on maintaining Body-Mind-Spirit harmony through diet, lifestyle, and natural herbs. Treatments are custom-tailored to individual needs, emphasizing balance rather than disease.

As a training institution, our services are for educational purposes and include:

- Body-Constitutional Analysis
- Diet and Lifestyle Counseling
- Ayurvedic Body Techniques
- Yoga and Meditation Practices

Our Ayurvedic treatments are complementary to conventional medicine. Please discuss any concerns with us and inform your medical doctor that you are receiving Ayurvedic advice.

I understand that this is an educational Ayurvedic consultation for purposes of helping me to improve my health and wellness. I understand this does not include medical diagnosis or medical treatment and is not a substitute for medical care. It is my responsibility to maintain a relationship with a medical doctor.2

_____ _____
Signature Date

By checking this _____ I certify that typing my name is equivalent to my signature.