ALA-AYURVEDA

AYURVEDA - PATIENT INTAKE

www.ala-ayurveda.com
email: aliciasudol.ayd@gmail.com **cell:** (831) 241-7785 **fax:** (224) 569-1179

Practitioner Name:

Appointment Date & Time:

Name:

Address:

City:

State:

Zip:

Telephone-Home:

Cell:

work:

Birthdate:

Age:

E-mail:

Occupation:

Marital/partner status:

# of children:

Ages:

Emergency Contract Name

Number

Please tell us why you have chosen to have an Ayurvedic Consultatton:

WHAT YOU CAN EXPECT FROM YOUR AYURVEDIC HEALTH CARE

Ayurveda is a natural healing system that has been successfully practiced for thousands of years. Originating in ancient India, this medical tradition states that each person's path toward optimal health is unique because each person is unique. The healing programs we offer at the Ala-Ayurveda are based on effective, time-honored principles that focus on understanding your particular body-mind constitution and the unique nature of your imbalance. Your program may include lifestyle adjustments, dietary changes, herbs, color therapy, sound therapy, aroma therapy, massage therapy, and other natural therapeutics. The goal of all Ayurvedic programs is to create within your body and mind an optimum environment for healing to take place and to maximize your body's ability to heal itself.

Patient's Signature:

Date:

PATIENT NAME:

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INFORMED CONSENT

All Patients who participate in Ayurvedic health care through this program should be advised of the following information:

1. Ayurvedic Doctors (AyD) are not trained in Western diagnosis or treatment and may not make suggestions about altering your medical care.
2. In the State of California Ayurveda is a non-licensed profession. Neither Ala-Ayurveda nor the services offered by any Ayurvedic practitioner, is licensed. The practice of Ayurveda as an alternative or complementary service was formally legalized under the passage of Senate Bill 577 in January 2003.
3. If you are suffering from a disease or symptom that has not been evaluated by a Medical Doctor or another license health care professional, we recommend that you receive a proper evaluation and may provide you with a referral form. If your AyD refer you to a Medical Doctor, you will be required to go or sign an acknowledgment that one was recommended to you.
4. Your AyD nor anyone in association with Ala-Ayurveda may recommend altering your prescription without the approval of your medical doctor. Your Ayd may suggest that you speak to your doctor about reducing medication when she feels that it is appropriate.
5. While your AyD may take your blood pressure and vital signs and perform some examination techniques similar to routine medical examination, the findings will be evaluated from an Ayurvedic perspective only and not from a Western medical perspective. This examination does not take the place of a medical evaluation. If, as a result of the examination any findings suggestive of a possible medical imbalance is found, your Ayd will refer you to a Medical Doctor for further evaluation.
6. Ayurveda is a complementary and alternative health care system. Care from your practitioner may be utilized as a complement to your current health care program.

I have read and understood the above disclosure about the Ayurvedic consultations and treatments offered by Ala-Ayurveda. I understand that my practitioner is not a licensed physician and that Ayurvedic services are not licensed by the state. I understand it is my responsibility to maintain a relationship for myself/my child with a medical doctor. I have consented to use the services offered by Ala-Ayurveda and agree to be personally responsible for the fees of Ala-Ayurveda in connection with the services provided to me.

Patients Signature: **Date**

FINANCIAL POLICY AGREEMENT

1. There is a charge of $190 for each initial consultation with an Ayurvedic Doctor (AyD).

2. There is a charge of $75 for each follow up visit with an AyD.

3. Your customized program often incorporates herbal formulas. There is a separate charge for herbs, preparation and shipping.

4. If you fail to show for your appointment without notice, or you cancel within 24 hours of your appointment, a $35.00 fee will be charged to your account. This includes on line and phone appointments.

Patients Signature: **Date**

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CONFIDENTIAL PATIENT HISTORY

FOR PRACTITIONER USE ONLY:

Practitioner Name: | **Initial Appointment:** | **ROF Date:**

(1) HISTORY OF THE CHIEF COMPLAINT

a. Main symton of disease: _____

b. How does the symptom or disease affect you: _____

_____

_____

c. Are there other related symptoms (if so, please note them here): _____

d. What is the date of onset of your condition: _____

e. What is the frequency of your experience (How many days out 9f each week do you experience the condition or symptom):

_____

f. Have you seen a medical doctor for this symptom / condition (If so, when):

_____

g. What is the name of your physician?: _____

h. What is the address and phone number of your physician: _____

(2) PAST MEDICAL HISTORY

Please list any major condition(s) and dates of diagnosis, treatmMt, and procedures performed.

a. What serious illnesses have you had?: _____

_____

b. Hospitalizations: _____

c. Operations: _____

d. List other pertinent current or past conditions: _____

_____

e. Have you had any cosmetic surgery or procedures performed? ☐ **Yes** ☐ **No**
if so please list

_____

f. Are you pregnant? ☐ **Yes** ☐ **No** ☐ **N/A**

(3) FAMILY HISTORY

Indicate what members of your immediate family have had these conditions. (Mother, Father, siblings, grandparents) (If adopted, answer according to family heritage, if known.)

☐ **High Blood Pressure:** _____ ☐ **Heart Disease:** _____
☐ **Cancer:** _____ ☐ **Mental Disorder:** _____
☐ **Stroke:** _____ ☐ **Diabetes:** _____
☐ **Other:** _____

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(4) ALCOHOL, TOBACCO AND SUBSTANCE USE

a. Do you drink alcoholic beverages? ☐ **Yes** ☐ **No**

If yes, how often: ☐ **Daily** ☐ **Several times weekly** ☐ **Several times monthly** ☐ **Seldom** **How many glasses:** _____

PRACTITIONER NOTES: _____

I usually choose : ☐ **Beer** ☐ **Wine** ☐ **Sweet or**

b. Have you ever smoked to bacco? ☐ **Yes** ☐ **No**

If yes, how much per day? _____ **If you have quit smoking tobacco, what year did you quit?** _____

Do you smoke marijuana? ☐ **Yes** ☐ **No** **If yes how much per day?** _____

PRACTITIONER NOTES: _____

c. Any current or past use of other addictive or habitual substances? ☐ **Yes** ☐ **No**
(Note: This will be kept confidential).
Please lest all substances (either current or long term past usage): _____

_____

PRACTITIONER NOTE: _____

(6) RELATIONSHIP

a. Please indicate how nourished you feel in your relationship (1 being the least nourished, 10 being the most nourished): _____
b. How often do you engage in sexual activity (include sex with partner and masturbation): _____
c. Is your current seual activity satisfactory? ☐ **Yes** ☐ **No**

(7) FOOD CHOICES (Please be as detailed as possible)

Please indicate which applies to your diet: ☐ **Daily** ☐ **Vegan** ☐ **Gluten-Fee** ☐ **Paleo** ☐ **Raw**
What percentage of your food is organic?

List below what types of foods you eat on a regular basis?

Breakfast:	
Lunch:	
Dinner:	
Snacks:	

(8) DAILY LIQUID INTAKE (Indicate number of 8 ounce cups per day

☐ **Caffeinated coffee/Tea:**	☐ **Herbal Tea or Juice:**	☐ **Decaffeinated Coffee/Tea**	☐ **Soda or Diet Soda:**
☐ **Plain water:**	☐ **Cow or Goat Milk:**	☐ **Grain/Nut/Soy Milk:**	

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(12) AYURVEDIC HISTORY

For each category please identify your tendency over time by placing an "X" in the box that is most appropriate for you. If you are unsure or would like to speak to your practitioner about this please use check mark in the column to the right.

CATEGORY				PRACTITIONER USE ONLY (FREQUENCY/INTENSITY 1-10)
Appetive	☐ I prefer to eat frequently but my hunger level is vanable and i often forget to eat. **Practitioner use only** ☐ V ☐ P	☐ I have a strong appetite i prefer to eat 3x/day and rarely skip meals. **Practitioner use only** ☐ V ☐ P	☐ I prefer to eat 2-3x/day, but i can go without eating with no discomfort. **Practitioner use only** ☐ V ☐ P	☐
Appetive	☐ If i mess a meal, I often get light-headed, anxious or cranly. **Practitioner use only** ☐ V ☐ P	☐ If i miss a meal, I often get critical or angry. **Practitioner use only** ☐ V ☐ P	☐ If i miss a meal, it doesn't really bother me. **Practitioner use only** ☐ V ☐ P	☐
Digestion	☐ After eating, I often experience gas or bloating. **Practitioner use only** ☐ V ☐ P	☐ After eating, I often experience heartburn or acidity. **Practitioner use only** ☐ V ☐ P	☐ After eating, I often feel heavy or sleepy. **Practitioner use only** ☐ V ☐ P	☐
Elemination	☐ I tend to have irregular bowel movements one time per day or less. **Practitioner use only** ☐ V ☐ P	☐ I tend to have 1 or more bowel movements daily, usually with regularly and ease. **Practitioner use only** ☐ V ☐ P	☐ I tend to have one bowel movement per day with no straining or difficulty. **Practitioner use only** ☐ V ☐ P	☐
Elemination	☐ My bowel movements are often dry and hard. At times i may strain or push. **Practitioner use only** ☐ V ☐ P	☐ My bowel movements are usually well-formed, but sometimes they are loose and may burn. **Practitioner use only** ☐ V ☐ P	☐ My bowel movements are usually well-formed, slow and easy. **Practitioner use only** ☐ V ☐ P	☐
Weight	☐ I usually dont gain weight very easily. **Practitioner use only** ☐ V ☐ P	☐ When I gain weight, it is easy to lose it. **Practitioner use only** ☐ V ☐ P	☐ I gain weight easily and lose it slowly. **Practitioner use only** ☐ V ☐ P	☐
Body Temperature	☐ My hands and feet often feel cold, and i prefer warmer climates. **Practitioner use only** ☐ V ☐ P	☐ I am warm most of the time no matter what the climate is. **Practitioner use only** ☐ V ☐ P	☐ I adapt easily to most conditions, but tend to feel cool. **Practitioner use only** ☐ V ☐ P	☐
Sleep	☐ I tend to sleep lightly and awaken very easily. It can be difficult for me to go to sleep. **Practitioner use only** ☐ V ☐ P	☐ I tend to sleep soundly and awaken with ease. **Practitioner use only** ☐ V ☐ P	☐ My sleep tends to be deep and long. It can be difficult for me to awaken in the morning **Practitioner use only** ☐ V ☐ P	☐
Skin	☐ My skin tends to be dry. When very dry it tends to feel rough. **Practitioner use only** ☐ V ☐ P	☐ My skin flushes easily and has a reddish or yellowish shade. **Practitioner use only** ☐ V ☐ P	☐ My skin is thick, smooth and often feels damp or oily. **Practitioner use only** ☐ V ☐ P	☐

PRACTITIONER USE ONLY:

V PRAKRUTI:	**P PRAKRUTI:**	**K PRAKRUTI:**
V VIKRUTI:	**P VIKRUTI:**	**K VIKRUTI:**

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(12) AYURVEDIC HISTOY CONTINUED

MENTAL & EMOTIONAL PATTERNS

CATEGORY				PRACTITIONER USE ONLY
Stress	☐ Under stress I often become worried or overwhelmed. Practitioner use only ☐V ☐P	☐ Under stress I often become irritable, but usually rise to the challenge. Practitioner use only ☐V ☐P	☐ Under stress, I often withdraw to observe or become reclusive. Practitioner use only ☐V ☐P	☐
Decision Making	☐ I am changeable and often have difficulty making decisions. Practitioner use only ☐V ☐P	☐ I make dicisions easily, but can change my mind with new information. Practitioner use only ☐V ☐P	☐ I am carefull but easy-going about decisions. Practitioner use only ☐V ☐P	☐
Projects	☐ I like to start projects, but at times have dificulty finishing them Practitioner use only ☐V ☐P	☐ I like to start and finish projects. Completion is important to me. Practitioner use only ☐V ☐P	☐ I like working on a project, but prefer to let others start them. Practitioner use only ☐V ☐P	☐
Personality	☐ When i am blanced i feel creative, enthusiastic, and vivacious. Practitioner use only ☐V ☐P	☐ When i am balanced i feel perceptive, discuplined, and logical. Practitioner use only ☐V ☐P	☐ When i am balanced I feel nurturing, calm, and devotional. Practitioner use only ☐V ☐P	☐

FOR WOMEN ONLY

			PRACTITIONER USE ONLY
Is there a possibility you are pregnant? ☐ Yes ☐ No ☐ Possible Are you menopausal? ☐ Yes ☐ No If yes, date of the last period ***If menopausal, please answer below according to your past menstrual patterns.***		I experience PMS: ☐ Possible ☐ Possible ☐ Not at all	☐
☐ My menstrual cycle is irregular. It comes every _____ to _____ days and lasts _____ days. Practitioner use only ☐V ☐P	☐ My menstrual cycle is regular. It comes every _____ days and lasts _____ days Practitioner use only ☐V ☐P	☐ Cramps ☐ Bloating ☐ Headache ☐ Weight gain ☐ Irritable ☐ Breast tenderness	☐
☐ My menstrual flow is irregular, light, 2-4 days. Practitioner use only ☐V ☐P	☐ My menstrual flow is heavy, regular, 3-5 days Practitioner use only ☐V ☐P	☐ My menstrual flow is regular, 5-6 days, sometimes clumping. Practitioner use only ☐V ☐P	☐
☐ I often have severe, cramping pain during menses. Practitioner use only ☐V ☐P	☐ At times, I have mild pain during menses. Practitioner use only ☐V ☐P	☐ I rarely have pain during menses. Practitioner use only ☐V ☐P	☐

PRACTITIONER USE ONLY:

V PRAKRUTI:	**P PRAKRUTI:**	**K PRAKRUTI:**
V VIKRUTI:	**V VIKRUTI:**	**K VIKRUTI:**

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(13) CHALLENGING PATTERNS

Please indicate any physical and emotional patterns that you find challenging by assigning a **frequency**(a number from 1 to 3) and **intensly**(a number from 1 to 10):

FREQUENCY	INTENSITY
1 = DAILY	1 TO 3 = MILD DISCOMFORT
2 = SEVERAL TIMES WEEKLY	4 TO 6 = MODERATE DISCOMFORT
3 = SEVERAL TIMES MONTHLY	7 TO 10 = SEVERE DISCOMFORT

A. DIGESTION	Frequency 1-3	Intenslty 1-10
Excessive gas		
Excessive belching		
Acid reflux		
Buming indigestion		
Nausea or vomiting		
Sleepy after eating		
Heaviness after eating		
Bloated after eating		

B. ELIMINATION	Frequency 1-3	Intenslty 1-10
Constipation (less then 1 BM/day)		
Alternating constipa-tion & diarrhea		
Food particles in stool		
Diarrhea		
Rectal pain or hem-orrhoids		
Blood in stool		
Mucus in stool		
Abdominal pain		

C. EMOTIONS	Frequency 1-3	Intenslty 1-10
Worry		
Anxlety		
Overwhelm		
Self-destructiveness		
Anger		
Resentment		
Critical/Blaming		
Intense		
Lethargic		
Melancholy		
Depression		
Stubbornness		

(14) ADDITIONAL SYMPTOMS OF CONCERN

List any symptoms of concern that you have not mentioned.

	Frequency 1-3	Intenslty 1-10

(15) PREVIOUSLY DIAGNOSED DISEASES OR CONDITIONS

List any diagnosed condition that you have not previously mentioned.

	Frequency 1-3	Intenslty 1-10

PRACTITIONER'S NOTES

Please describe symptoms of diagnosed condition

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(16) CURRENT MEDICATIONS, HERBS and SUPPLEMENTS

What medications, herbs, and supplements are you currently taking?
Please include significant remedies that you have stopped taking including birth control and hormone replacement therapies.

Substance	Over-the-counter(OTC Prescription? (Rx)	Herb/Drug/ Vitamin?	Prescribed by? (Self, MD, other)	For what purpose?	For how long?	what dosage?	What have the benefits been?

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HIPPA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health information
(Required by the health Insurance Portability and Accountability Act-45 CFR parts 160 and 164)

Patients Name: **Date of Birth:**

1. Authorization for release of Protected Health Information ('PHI") covering the period of health care (check one)

a. ☐ From (date) _____ to (date) _____ OR

b. ☐ All past, present and future periods.

2. I hereby authorize the release of PHI as follows (check one):

a. ☐ My complete health record (including records relation to mental health care, communicable disases, HIV or AIDS, and treatment of alcohol/ drug abuse) OR

b. ☐ My complete health record with the exception of the following information (check as appropriate):

☐ Mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/ drug abuse treatment

☐ Other (please specify): _____

3. In addition to the authorization for release of my PHI described in paragraphs 2 a and 2 b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individuals.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

4. Tis medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes I may direct.

5. This authorization shall be in force and effect until nine (9) months after my death or _____ (date or event) at which time this authorization expires,

6. I understand that i have the right to revoke this authorization, in writing, at any time, I understand that are vocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for the benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization my be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient/Guardian: **Date:**

Keep original, and give copies to your health care provider, agent or family members

PATIENT NAME: