

Initial Client Questionnaire

Please fill out marked sections

Date: _____

Personal Data:

Name: _____

E-mail address: _____

Telephone (cell): _____

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? Or, Any significant previous health concerns or problems?

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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:

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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

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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? 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

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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

Environment

1. What direction does your house face? (N/NE/E/SE/S/SW/W/NW) _____
2. What side of the house do you enter? (N/NE/E/SE/S/SW/W/NW) _____
3. What direction does your head of your bed point towards? (N/NE/E/SE/S/SW/W/NW) _____
4. Do you live near a power plant or high tension wires? Yes No
5. Are you exposed to chemicals, pesticides or other toxins on a regular basis? Yes No
6. Have you recently painted or renovated your home or office? 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: _____

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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:

BRIEF PRAKRITI ASSESSMENT BY DOSHA PREDOMINANCE

Feature	Relative Score	Vata	V	Pitta	P	Kapha	K
Face/Complexion	5	Oval or thin, pale or grayish complexion		Reddish or ruddy complexion, early wrinkling		Fair, clear, “glowing” complexion	
Psychomotor movements/ Gait/ Speech	5	Quick, always moving		Purposeful, sharp, precise, stable		Methodical, relaxed, slow, stable	
Body weight	7.5	Light		Medium		Heavy	
Body frame	7.5	Small-boned, bony, angular; less muscular		Medium frame and musculature		Large frame, sturdy, plump, good/large musculature	
Joints	5	Prominent bony protuberances		Medium		Rounded, well-covered	
Eyes, size and shape	2.5	Small, deep-set or protuberant		Medium size, sharp or penetrating appearance		Large	
Tendons and Veins	5	Prominent, very visible		Medium prominence and visibility		Well-covered, hidden	
Abdominal wall thickness	5	Thin		Medium		Thick (increased adipose tissue)	
Skin quality	5	Tends toward dryness		Fair, burns easily		Tends toward oiliness	
Temperature intolerance	2.5	Cold temperature		Hot temperature		Cool and damp, or comfortable at most temperatures	
Typical emotional reaction to challenges	2.5	Worry, anxiety		Anger, irritability		Generally remains stable, calm	
Physical strength and stamina	2.5	Variable or low compared to others.		Medium to strong compared to others.		High compared to others.	
Type of digestion	Insert V-P-K scores from Digestion Assessment						
Totals for V-P-K							

DIGESTION ASSESSMENT BY DOSHA PREDOMINANCE

Question	Relative Score	Vata	V	Pitta	P	Kapha	K
Is your hunger	1	Irregular, varies from meal to meal.		Generally strong; cannot skip meals.		Mild; can generally easily skip meals.	
After eating, speed of digestion (time it takes to feel hungry again) is	1	Irregular, varies from meal to meal.		Quick; I feel hungry again after only a couple of hours.		Slow; I'm not hungry again for 5-6 hours.	
Food capacity (amount you can eat at a time)	1	Varies from meal to meal.		Large as compared to most other people.		Small as compared to most other people.	
Fluctuations of body weight	1	Easy to lose, difficult to gain; I tend to be underweight.		Can maintain normal weight even with fairly large food intake.		I gain weight easily, even with moderate food intake. Difficult to lose weight.	
Energy level	1	Variable or low compared to others.		Abundant compared to others.		Good, but may tend toward laziness.	
Regularity of bowel movements	1	Irregular, tending toward constipation.		Frequent; often more than 1-2 times a day.		Regular, once or twice daily.	
Quality of stool	1	Hard, dry.		Loose.		Well-formed.	
Add 1 point for each of the symptoms listed	1 per each symptom	a. Gas or bloating b. Frequent belching c. Constipation d. Intestinal cramping or discomfort		a. Acid stomach b. Reflux (heartburn) c. Diarrhea tendency		a. Sluggish digestion (regularly, not variable) b. Heaviness or sleepy after eating (often) c. Stool sticky or with mucus	
Totals for V-P-K							

General Health Survey

Please mark to what degree the following statements apply to you (1=0% and 5=100%)

	0%	25%	50%	75%	100%
1. I tend to feel obstruction/ blockages in the body. <i>(Constipation, congestion/heaviness in the head area, blocked nose, general feeling of non-clarity, or other)</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
2. When I wake up in the morning, I do not feel clear; it takes me quite some times to feel really awake.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
3. I tend to feel tired or exhausted mentally and physically.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
4. I get common colds or similar ailments several times a year.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
5. I tend to feel heaviness in the body.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
6. I tend to feel that something is not functioning properly in the body. <i>(breathing, digestion, elimination, or other)</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
7. I tend to be lazy, e.g., the capacity to work is there, but there is no inclination.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
8. I often suffer from indigestion.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
9. I tend to have to spit repeatedly.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
10. Often I have no taste for food and no real appetite.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
11. My tongue is often coated especially in the morning.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>