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SimpleVeda
A Simple Approach to Healthy Living Based on Ancient Yogic Wisdom
earth water fire air ether

**3525 CEDAR SPRINGS RD. DALLAS, TX 75219**
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**Phone: (214) 702-6825 ♦**

# ♦ CONFIDENTIAL CLIENT HISTORY ♦

Appointment Date & Time: _____

Name: _____

Address: _____

City, State, Zip: _____

Telephone—Home:_____ Cell: _____ Work: _____

E-mail: _____ Birthdate:_____ Age: _____

Marital/partner status:_____ # of children:_____Ages:_____

Occupation:_____

How did you hear about Ayurveda/SimpleVeda?_____

Please tell us why you have chosen to have an Ayurvedic Consultation: _____

_____

_____

## 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 are based on effective, time-honored principles that focus on understanding your particular body-mind constitution and the unique nature of your imbalance.

Each individualized program is formulated for by your practitioner. Your program may include lifestyle adjustments, dietary changes, herbs, color therapy, sound therapy, aroma therapy, massage therapy, and other natural therapeutics. In order to successfully implement these Ayurvedic principles into your life, frequent regular follow-up visits with your practitioner are recommended over a six- to twelve-month period.

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 (or Guardian) Signature: _____ Date: _____

# INFORMED CONSENT AND DISCLAIMER

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

1. An Ayurvedic Health Practitioner is not trained in Western diagnosis or treatment and will not make suggestions about altering your medical care or medications. In the United States, Ayurveda is a non-licensed profession. Its practice was formally legalized under Senate Bill 577 in January 2003.
2. By changing your lifestyle and living more harmoniously, you will create within your body the optimum environment for healing to take place and a greater sense of well-being that will help you to thrive and not simply survive.
3. If you have specific symptoms that you are concerned about that has not been evaluated by a medical doctor or another licensed healthcare professional, we recommend that you receive a proper evaluation.
4. If you are under medical care or the care of another healthcare provider, your work with your Ayurvedic Health Practitioner will compliment the work being done by your other providers.
5. If you are not under the care of another healthcare provider, the work that you do with your Ayurvedic Health Practitioner will help prevent disease and support your overall well-being.
6. As part of your initial consultation we may take your blood pressure and vital signs, and perform some examination techniques similar to a routine medical examination, we are evaluating our findings 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 their examination, any findings suggestive of a possible medical imbalance is found, we will refer you to a Medical Doctor for further evaluation.**
7. By signing below, you have read and understand the above information and give your permission to SimpleVeda to begin a program of Ayurvedic health care with a Ayurvedic Health Practitioner.

Patient (or Guardian) Signature: _____ Date: _____

## *CANCELLATION POLICY:*

Our goal is to provide quality care and attention to each client. In order to do so we have implemented a cancellation policy. The policy enables us to better utilize available appointments for our patients in need of care.

If it is necessary to cancel your scheduled appointment we require that you **call by 10 a.m. one (1) working day prior to your scheduled appointment**. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to care.

**How to Cancel Your Appointment**

To cancel appointments please call 214-702-6825. If you do not reach someone, please leave a detailed message on the voice mail. You may not cancel via email. **If an appointment is cancelled after 10 a.m. one (1) working day prior to your scheduled appointment you will be charged 50% of the scheduled service.**

Patient (or Guardian) Signature: _____ Date: _____

# CONFIDENTIAL PATIENT HISTORY

## (1) PAST MEDICAL HISTORY

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

a. Are you under the care of a licensed health care professional or any other healthcare provider? ☐ Yes ☐ No

If so, for what reasons: _____

_____

b. Serious illnesses: _____

_____

c. Hospitalizations: _____

d. Operations: _____

e. List other pertinent past conditions: _____

_____

f. Have you had any cosmetic surgery or procedures performed? ☐ Yes ☐ No

If so, please list: _____

_____

## (2) FAMILY HISTORY

Indicate what members of your immediate family have had these conditions. (Go back one generation)
*(If adopted, answer according to family heritage, if known.)*

☐ High Blood Pressure _____ ☐ Heart Disease _____ ☐ Other _____

☐ Cancer _____ ☐ Mental Disorder _____ _____

☐ Stroke _____ ☐ Diabetes _____ _____

## (3) ALCOHOL, TOBACCO AND SUBSTANCE USE

| | PRACTITIONER NOTES: |
|---|---|
| **a**. Do you drink alcoholic beverages? ☐ Yes ☐ No<br>If yes, how often: ☐ *Daily* ☐ *Several times weekly* ☐ *Several times monthly* ☐ *Seldom*<br>I usually choose: ☐ beer ☐ wine ☐ sweet or hard liquor | |
| **b**. Have you ever smoked tobacco? ☐ Yes ☐ No If yes, how much per day?_____<br>If you have quit smoking, when did you quit? _____ | |
| **c**. Any current or past use of addictive or habitual substances? ☐ Yes ☐ No ***(Note: This will be kept confidential)*** Please list all substances (either current or long-term past usage):_____<br>_____<br>_____ | |

## (4) REGULAR PRACTICES

| | | | |
|---|---|---|---|
| ☐ EXERCISE/HATHA YOGA *(Specify)* | ☐ *None/Never* | ☐ *Occasional*<br>☐ *Daily* | ☐ *Several times per week*<br>☐ *Several times per month* |
| ☐ TEAM SPORTS/RECREATION *(Specify)* | ☐ *None/Never* | ☐ *Occasional*<br>☐ *Daily* | ☐ *Several times per week*<br>☐ *Several times per month* |
| ☐ TRAVEL *(Include commute if applicable)* | ☐ *None/Never* | ☐ *Occasional*<br>☐ *Daily* | ☐ *Several times per week*<br>☐ *Several times per month* |
| ☐ SPIRITUAL PRACTICES *(Specify)* | ☐ *None/Never* | ☐ *Occasional*<br>☐ *Daily* | ☐ *Several times per week*<br>☐ *Several times per month* |
| ☐ MEDITATION/PRAYER/PRANAYAMA *(Specify)* | ☐ *None/Never* | ☐ *Occasional*<br>☐ *Daily* | ☐ *Several times per week*<br>☐ *Several times per month* |
| ☐ OTHER *(Include creative activities)* | ☐ *None/Never* | ☐ *Occasional*<br>☐ *Daily* | ☐ *Several times per week*<br>☐ *Several times per month* |

## (5) SEXUAL ACTIVITY

*According to Ayurveda, a person's level of sexual activity impacts health and well-being in the same way as other aspects of daily life--such as diet or sleep.*

a. How often do you engage in sexual activity (include sex with partner and masturbation):

☐ *Daily* ☐ *Several times per week* ☐ *Several times per month* ☐ *Occasionally* ☐ *Not at all*

b. Is your current sexual activity satisfactory? ☐ *Yes* ☐ *No*

## (6) FOOD CHOICES

What types of foods do you eat on a regular basis?

BREAKFAST:

LUNCH:

DINNER:

SNACKS:

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

☐ Plain water _____

☐ Caffeinated Coffee/Tea _____ ☐ Herbal Tea or Juice _____ ☐ Cow or Goat Milk _____

☐ Decaffeinated Coffee/Tea _____ ☐ Soda or soda pop _____ ☐ Grain/nut/soy milk _____

## (8) HABITUAL EATING PATTERNS

Describe any current or past eating patterns or any other food related issues.

## (9) DAILY SCHEDULE *(include approximate times)*

What are your habitual activities from the time you wake up until you go to sleep? Include mealtimes, sleeping, exercise, work, and any activities that occur on a regular basis.

| | | TIME | HABITUAL ACTIVITIES | NOTES |
|---|---|---|---|---|
| MORNING | Awaken | | | |
| | Mealtime | | | |
| | Activities | | | |
| | | | | |
| DAY | Mealtime | | | |
| | Activities | | | |
| | | | | |
| NIGHT | Mealtime | | | |
| | Activities | | | |
| | Bed-time | | | |

## (10) ALLERGIES OR SENSITIVITIES

Do you have allergic reactions to any substances (including food, pollens, medicines)? If yes, please list.

_____

## (11) 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 check (√ ) in the column to the right.

| | | | |
|---|---|---|---|
| Appetite | My hunger level is variable, and I often forget to eat. ☐<br>*Practitioner use only* V☐ P☐ | I have a strong appetite and don't like to miss meals. ☐<br>*Practitioner use only* V☐ P☐ | I like to eat, but I can go without eating with no discomfort. ☐<br>*Practitioner use only* V☐ P☐ |
| Appetite | If I miss a meal, I often get light-headed, anxious or cranky. ☐<br>*Practitioner use only* V☐ P☐ | If I miss a meal, I often get irritable or angry. ☐<br>*Practitioner use only* V☐ P☐ | If I miss a meal, it doesn't really bother me. ☐<br>*Practitioner use only* V☐ P☐ |
| Appetite | I prefer to eat frequently with no set schedule, but I often forget to eat. ☐<br>*Practitioner use only* V☐ P☐ | I prefer to eat 3 meals a day at about the same time. I rarely skip meals. ☐<br>*Practitioner use only* V☐ P☐ | I prefer to eat 2 to 3 times daily, but can go without eating. ☐<br>*Practitioner use only* V☐ P☐ |
| Digestion | After eating, I often experience gas or bloating ☐<br>*Practitioner use only* V☐ P☐ | After eating, I often experience heartburn or acidity. ☐<br>*Practitioner use only* V☐ P☐ | After eating, I often feel heavy or sleepy. ☐<br>*Practitioner use only* V☐ P☐ |
| Elimination | I tend to have irregular bowel movements one time per day or less. ☐<br>*Practitioner use only* V☐ P☐ | I tend to have 1 to 2 bowel movements daily, usually with regularity and ease. ☐<br>*Practitioner use only* V☐ P☐ | I tend to have one bowel movement per day with no straining or difficulty. ☐<br>*Practitioner use only* V☐ P☐ |

| | | | |
|---|---|---|---|
| Elimination | My bowel movements are often dry and hard. At times I may strain or push. ☐<br>*Practitioner use only* V☐ P☐ | My bowel movements are usually well-formed, but sometimes they are loose and may burn. ☐<br>*Practitioner use only* V☐ P☐ | My bowel movements are usually well-formed, slow and easy. ☐<br>*Practitioner use only* V☐ P☐ |
| Weight | I usually don't gain weight very easily. ☐<br>*Practitioner use only* V☐ P☐ | When I gain weight, it is easy to lose it. ☐<br>*Practitioner use only* V☐ P☐ | I gain weight easily and lose it slowly. ☐<br>*Practitioner use only* V☐ P☐ |
| Body Temperature | My hands and feet often feel cold, and I prefer warmer climates. ☐<br>*Practitioner use only* V☐ P☐ | I am warm most of the time no matter what the climate is. ☐<br>*Practitioner use only* V☐ P☐ | I adapt easily to most conditions, but tend to feel cool. ☐<br>*Practitioner use only* V☐ P☐ |
| Skin | My skin tends to be dry. When very dry it tends to feel rough. ☐<br>*Practitioner use only* V☐ P☐ | My skin flushes easily and has a reddish or yellowish shade. ☐<br>*Practitioner use only* V☐ P☐ | My skin is thick, smooth and often feels damp or oily. ☐<br>*Practitioner use only* V☐ P☐ |

| | | | |
|---|---|---|---|
| Skin | When I have rashes, they tend to be dry and itchy. Blemishes are usually blackheads. ☐<br>*Practitioner use only* V☐ P☐ | When I have rashes, they tend to be red and burning. Blemishes are usually acne. ☐<br>*Practitioner use only* V☐ P☐ | When I have rashes, they tend to be wet and oozing. Blemishes are usually white pimples. ☐<br>*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. ☐<br>*Practitioner use only* V☐ P☐ | I tend to sleep soundly and awaken with ease. ☐<br>*Practitioner use only* V☐ P☐ | My sleep tends to be deep and long. It can be difficult for me to awaken in the morning. ☐<br>*Practitioner use only* V☐ P☐ |

## MENTAL & EMOTIONAL PATTERNS

| | | | |
|---|---|---|---|
| Stress | Under stress I often become worried or overwhelmed. ☐<br>*Practitioner use only* V☐ P☐ | Under stress I often become irritable, but usually rise to the challenge. ☐<br>*Practitioner use only* V☐ P☐ | Under stress, I often withdraw to observe or become reclusive. ☐<br>*Practitioner use only* V☐ P☐ |
| Decision Making | I am changeable and often have difficulty making decisions. ☐<br>*Practitioner use only* V☐ P☐ | I make decisions easily, but can change my mind with new information. ☐<br>*Practitioner use only* V☐ P☐ | I am careful but easy-going about decisions. ☐<br>*Practitioner use only* V☐ P☐ |
| Projects | I like to start projects, but at times have difficulty finishing them. ☐<br>*Practitioner use only* V☐ P☐ | I like to start and finish projects. Completion is important to me. ☐<br>*Practitioner use only* V☐ P☐ | I like working on a project, but prefer to let others start them. ☐<br>*Practitioner use only* V☐ P☐ |

## FOR WOMEN ONLY

Is there a possibility you are pregnant? ☐***Yes*** ☐***No*** ☐***Possible***
Are you menopausal? ☐***Yes*** ☐***No*** If yes, date of last period _____
*If menopausal, please answer below according to your past menstrual patterns.*
_____
*Practitioner use only* V☐ P☐

I experience PMS:
☐*often* ☐*sometimes* ☐*not at all*

☐*cramps* ☐*bloating*
☐*headache* ☐*weight gain*
☐*irritable* ☐*breast tenderness*
_____
*Practitioner use only* V☐ P☐

| | | |
|---|---|---|
| My menstrual cycle is irregular. It comes every ___ to ___ days and lasts ___days. ☐<br>*Practitioner use only* V☐ P☐ | My menstrual cycle is regular. It comes every ____ days, and lasts _____ days. ☐<br>*Practitioner use only* V☐ P☐ | |
| My menstrual flow is often light, but may vary. ☐<br>*Practitioner use only* V☐ P☐ | My menstrual flow is medium heavy, and is usually consistent. ☐<br>*Practitioner use only* V☐ P☐ | My menstrual flow is heavy and is very consistent. ☐<br>*Practitioner use only* V☐ P☐ |
| I often have severe, cramping pain during menses. ☐<br>*Practitioner use only* V☐ P☐ | At times, I have mild pain during menses. ☐<br>*Practitioner use only* V☐ P☐ | I rarely have pain during menses. ☐<br>*Practitioner use only* V☐ P☐ |

## MENTAL AND EMOTIONAL PATTERNS

| *When I am having a bad day, I am challenged by:* | | | | *When I am having a good day and feeling at ease, I would describe myself as:* | |
|---|---|---|---|---|---|
| **Emotion** | **Scale of 1 to 10 (1 is the mildest and 10 is the strongest** | **Frequency: Number of times per week, month of year** | | **Personality** | **Scale of 1 to 10 1 seldom and 10 most often** |
| **Worry** | | | | **Creative** | |
| **Anxiety** | | | | **Enthusiastic** | |
| **Overwhelm** | | | | **Vivacious** | |
| **Self-destructiveness** | | | | **Thoughtful** | |
| **Anger** | | | | **Philosophical** | |
| **Resentment** | | | | **Perceptive** | |
| **Jealousy** | | | | **Disciplined** | |
| **Intensity** | | | | **Logical** | |
| **Rage/Violence** | | | | **Nurturing** | |
| **Melancholy** | | | | **Calm and stable** | |
| **Depression** | | | | **Unconditionally loving** | |
| **Stubborn** | | | | | |
| **Controlling** | | | | | |
| **Apathetic** | | | | | |
| **Sentimental** | | | | | |

**PLEASE DESCRIBE YOUR CURRENT EMOTIONAL STATE:**

_____

_____

_____

_____

**PRACTITIONER USE ONLY:**

_____

_____

_____

_____

**VIKRUTI**

| V | P | K |
|---|---|---|
| | | |

**PRAKRUTI**

| V | P | K |
|---|---|---|
| | | |

## (12) CURRENT MEDICATIONS, HERBS OR SUPPLEMENTS

What medications, herbs, 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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