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NOTE: This form has 11 pages - use the navigation tools on the upper right side of the screen to move from page to page.

CLIENT INTAKE FORM

Date

Name

Address

City, State, Zip

Email

Telephone ☐ cell ☐ home ☐ work

Age

Birth date Birth place Time of birth

Marital/partner status # children Ages

Occupation

Emergency Contact

Name

Address

City, State, Zip

Telephone Relationship

How did you hear about Valley Ayurveda?

Please add me to your email mailing list. ☐ yes ☐ no

Valley Ayurveda, 98 Main St, Northampton MA 01060 - 413.727.8573 - www.valleyayurveda.com

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STATEMENT OF UNDERSTANDING

I understand that Brooksley Williams at Valley Ayurveda is an Ayurvedic Consultant and Educator who can provide me with information on the Ayurvedic approach to health care, which may affect my diet and health in a positive way. I understand that she is not a medical doctor or licensed medical practitioner, has not presented herself as such, and does not seek to diagnose, treat or prescribe for disease, disorder or other pathological conditions. I agree that I am interested in enhancing my own abilities to heal and establish health in mind and body, and this is the reason I have sought these Ayurvedic consulting services. I agree that I may consult a licensed physician for any concern, at any time, about any disease or pathology, which now exists or arises at any time during my professional relationship with my practitioner at Valley Ayurveda.

Furthermore, I understand that Brooksley Williams at Valley Ayurveda encourages regular medical checkups from a licensed medical professional of my choice. I understand that only a licensed physician of my choice can advise on medication dosages or the discontinuance or resumption of such medication.

My signature below acknowledges the above statements as fully read and understood.

Client's Signature: _____ Date: _____

FINANCIAL POLICY AGREEMENT

1. Valley Ayurveda does not bill insurance companies for services.
2. Payment is due at the time of service.
3. If I miss an appointment with my clinician without giving 24 hours notice, I agree to pay for the service in full.

I have read and understood the financial policies of Valley Ayurveda, LLP.

Client's Signature: _____ Date: _____

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PRIMARY HEALTH CONCERNS

What are your main health concerns at this time?

PRIMARY CONCERNS	CLINICIAN NOTES
1.	
2.	
3.	
4.	
5.	

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MEDICAL HISTORY

Physician's Name

Physician's Address/Phone

May we share information about your treatment plan with your physician? ☐ yes ☐ no

Past Medical History

Please include major conditions, dates of treatment, procedures performed.

1. Serious Illness:
2. Hospitalizations:
3. Operations:
4. Other conditions we should know about?
5. Have you been under the care of a health professional in the past year? ☐ yes ☐ no

   If so, for what reasons?
6. Is there any possibility you are pregnant? ☐ yes ☐ no

Medications & Supplements

What medications, herbs, and/or supplements are you currently taking? Please also include any significant medications and/or supplements that you have recently stopped taking. Please use the additional space on page 5 or 9 if you need more room.

Name of Substance	Type of Substance	Dosage	Prescribed or Recommended by	Purpose	Duration of use?	Side effects?
	☐ herbal ☐ OTC ☐ vitamin ☐ Rx ☐ other					
	☐ herbal ☐ OTC ☐ vitamin ☐ Rx ☐ other					
	☐ herbal ☐ OTC ☐ vitamin ☐ Rx ☐ other					
	☐ herbal ☐ OTC ☐ vitamin ☐ Rx ☐ other					
	☐ herbal ☐ OTC ☐ vitamin ☐ Rx ☐ other					

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MEDICAL HISTORY CONTINUED

Allergies or Sensitivities

Please list any allergies or sensitivities. Use additional blank space below if necessary.

Name of Substance	Reaction

Family History

Please check the appropriate box and indicate which family member.

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

Additional Medical History

Please use this space to provide additional information on your medical history.

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DAILY RHYTHM ANALYSIS

What time do you wake up?

What do you do when you get up?

What is your work day like?

What time do you go to bed?

Do you have any bedtime routines?

How is your sleep? Do you have trouble falling or staying asleep? How many hours of sleep do you get per night?

DIGESTION AND ELIMINATION

Do you have a morning bowel movement?

How many BMs do you have a day?

What is the consistency of your BMs?

Any gas, bloating, diarrhea, constipation, acid indigestion or reflux? Please explain.

MENSTRUATION

At what age did you start your period?

Are you still menstruating? If not, at what age did you stop? Was it natural or induced (i.e., hysterectomy, oophorectomy, etc.)

Please describe your menstrual cycle (# days, quality of the flow, time between periods, pain, PMS, etc.).

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DIET

How is your appetite? ☐ Irregular ☐ I must eat as soon as I feel hungry ☐ Always hungry

Any current or past issues with eating disorders or other food-related issues? ☐ Yes ☐ No

When and what do you eat...

Breakfast

Lunch

Dinner

Has your weight fluctuated more than +/-5 pounds in the past 5 years? 10 years? Please explain.

How many cups of caffeinated beverages do you drink per day? What form do they take (e.g., coffee, soda, black tea)

How many cups of non-caffeinated beverages (excluding water) do you drink per day? What type?

How much water do you drink per day? At what temperature (e.g., hot, warm, room-temp, with ice)?

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GENERAL HEALTH HABITS

Are you a former smoker? ☐ Yes ☐ No Amount/day ☐ #Years ☐ Quit date ☐

Do you currently smoke? ☐ Yes ☐ No Amount/day ☐ #Years ☐

Would you like to quit? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No Amount/wk ☐ Type(s) ☐

Do you use recreational drugs? ☐ Yes ☐ No Amount/wk ☐ Type(s) ☐

Any current or past problems with addiction or substance abuse? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No Frequency? ☐

Do you exercise? How often? What do you do? ☐

RELATIONSHIPS

With whom do you live? What's the atmosphere like at home? ☐

Are you close with your family? ☐

Do you like your job? What's the atmosphere like at work? ☐

Do you feel like you have a solid emotional support system in your life through friends and/or family? ☐

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ADDITIONAL INFORMATION

How do you "de-stress?"

Please use the space below to elaborate on any questions or add any other information you'd like us to know.
Thank you!

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CONSTITUTION QUESIONNAIRE

When answering these questions, go as far back as you can remember, to your youth and early adult years. Identifying those characteristics that you were born with will help to ascertain your constitution. Generally pick one per category (though in some cases there may be more than one) and click the appropriate box.

Mental Profile	Vata		Pitta		Kapha	
Mental activity	quick, active, restless		sharp, critical, aggressive		calm, steady, slow, stable	
Memory	good 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 info		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	
SUBTOTAL						

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 amts infrequently		gives regularly and generously	
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 is a big spender		saves regularly, accumulates wealth	
Routine	dislikes routine		likes planning & organizing		works well with routine	
SUBTOTAL						

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CONSTITUTION QUESTIONNAIRE CONTINUED

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 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	
SUBTOTAL						

Physical Profile	Vata		Pitta		Kapha	
Amount of hair	average		thinning		thick	
Hair type	dry, frizzy, thin, dark		straight, fine, premature graying		oily, wavy, thick	
Original hair color	light brown, blonde		auburn, reddish		dark brown, black	
Skin	dry/rough/both; dark or sallow; tans easily		soft, normal-oily, light, sunburns, warm		oily, moist, fair, thick, 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 the day, soft to normal		heavy, slow, thick, regular	
Sweat	scanty		profuse		moderate	
SUBTOTAL						

TOTAL						

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