Dhanvantari Ayurveda Center -- Ayurveda Education Programs

Personal Health History

Name: Telephone ( ) Date:

Address +ZIP Code

Birthplace, Date, and Time (Optional)

Occupation: Marital Status: e-mail:

Please indicate the area(s) you want assistance with and the priority—(1) is first, etc.
Diet Lifestyle Emotion Spirituality Other

CURRENT STATE OF HEALTH:

Current age Current weight Current height

Please indicate with a mark (X) if you are experiencing any of the following in a recurring way:

Dryness		Bleeding		Congestion		Coating on tongue	
Gas		Bruising		Food allergies		Low grade fever	
Insomnia		Skin rashes		Respiratory allergies		Excess sleep	
Bloating		Migraines		Edema		Aches and pains	
Constipation		Inflammation		Heaviness		Malaise	
Worry		Infection		Dullness		Sluggish elimination	
Fear		Excess body warmth		Attachment		Lethargy	
Anxiety		Anger		Depression		Lack of energy	
Indecisiveness		Impatience		Greed		Lack of appetite	
Muscle twitching		Judgmental		Dull, vague pain		Stress at home/work	
Cramping		Diarrhea		Cold, clammy hands			
Numbness		Nausea		Excess sweating			
Stiffness		Vomiting		Frequent urination			
Shifting/tearing pain		Burning sharp pain		Stuffiness			
Dry cough		Tenderness to touch					
Ungroundedness							

You been exposed to any (environmental) toxins?	
You have any allergic reactions?	
You FREQUENTLY wear leather garments?	
Dry Cleaned Garments?	
You have/ had mercury dental amalgam fillings?	
You wear predominantly natural fiber clothing (cotton, silk, wool) ?	

FOR LADIES: menstruation regular? discomfort with menstruation? ovulation?
FOR MEN: You experience pain with urination? restricted urination? impotence?

DAILY ROUTINE: (If completing on computer choose insert "on" and place "X" in appropriate space.)

Time you go to bed? Get up? Upon awaking you feel: rested tired
Your sleep is: profound superficial interrupted / restless
You nap? What time of day?
You exercise? Regularly? Kind of Exercise:
You have a bowel movement upon rising?
Your bowel movements are: difficult soft formed floating
Frequency of Bowel movements are: once a day more than once a day less than once a day
You are hungry for: breakfast lunch dinner
Times you take your meals: Breakfast Lunch Dinner
You observe regular meal times You snack between meals
There are foods or tastes you do NOT tolerate or are in some way sensitive to? Name?
You are vegetarian? You eat a whole protein in each meal?
How much fluids do you drink daily? You drink caffeinated beverages? carbonated beverages?
You drink cold beverages? You drink more than 8 ounces of fluids with meals?

PRESENT HEALTH STATUS: Please list or describe all diseases or conditions including mental state you are PRESENTLY diagnosed with:

Please indicate the time of onset of the above and any known or suspected causes or significant events associated with onset:

PAST HEALTH HISTORY: Please indicate conditions or diseases you have been diagnosed with or any other signs or symptoms you may have suffered with that are not of present history.

GENETIC BACKGROUND: Please provide names of any diseases / conditions of your close family relatives.

Please List the names (and for which condition) of all medications / food supplements you are presently taking.

Is there an important event (s) which has/have shaped your life?: