HOUSTON YOGA & AYURVEDA ASHRAM INC.

♦AYURVEDA DOSHA INTAKE FORM♦

Appointment Date & Time: _____

Name: _____ Address: _____ City, State, Zip: _____, _____ _____

Home: _____-_____-_____ Cell: _____-_____-_____ Work: _____-_____-_____

E-mail: _____ Birth date: _____ Age: _____

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

Occupation: _____

How did you hear about the Houston Yoga & Ayurveda Ashram Center Program? _____

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

FINANCIAL POLICY AGREEMENT

1. There is a $ 225 charge for each consultation with a Clinical Ayurvedic Specialist
2. There is a $ 99 charge for each follow-up visit with a Clinical Ayurvedic Specialist.
   - Your customized program often incorporates herbal formulas designed by your specialist. There is a charge for herbal formula design, preparation and shipping.
     The Specialist should always inform you of these costs before ordering the herbs.
3. Payment for herbs and consultations may be made by check, credit or cash.
4. HYA does not bill insurance companies for services or herbs.
5. If Pancha Karma services are recommended and provided at HYA, payment for those services is made when the appointments are scheduled.
6. If you miss an appointment with your Specialist without giving 24 hours notice, a $50.00 fee is charged to your account.
7. I have read and understood the financial policies of the Houston Yoga & Ayurveda Ashram.

Participant's Signature: _____Date: _____

Name:_____, Address:_____

HOUSTON YOGA & AYURVEDA ASHRAM INC.

INFORMED CONSENT

to authorize Complementary or Alternative Health Care

All Participates of Ayurvedic health care through this program please be advised of the following information:

1. The Houston Yoga & Ayurveda Ashram is not a Medical Facility.
2. Ayurvedic Specialists are not trained in Western diagnosis or treatment and may not make suggestions about altering your medical care.
3. Sharon Kapp, the founder and director of the Houston Yoga & Ayurveda Ashram, is an Alternative Medical Specialist in Ayurvedic Medicine. She is not an Allopathic Medical Doctor.
4. Sharon Kapp is a graduate of the California College of Ayurveda.
5. In the State of California or Texas, Ayurveda is a non-licensed profession. Its practice was formally legalized under the passage of California Senate Bill 577 in January 2003.
6. If you are suffering from a disease or symptom that has not been evaluated by a Medical Doctor or another licensed health care professional, we recommend that you receive a proper evaluation and may provide you with a referral form. If your intern refers you to a Medical Doctor, you will be required to go or sign an acknowledgment that one was recommended to you.
7. Neither your Specialist nor anyone in association with the Houston Yoga & Ayurved Ashram may recommend altering your prescriptions without the approval of your medical doctor. Your Specialist may suggest that you speak to your doctor about reducing medication when he/she feels that it is appropriate.
8. While your Specialist may take your blood pressure and vital signs, and perform some examination techniques similar to a routine medical examination, your intern is evaluating their 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 are found that suggest a possible medical imbalance, your Specialist will refer you to a Medical Doctor for further evaluation.
9. By signing below, you give your permission to the Houston Yoga & Ayurveda Ashram to use the information in your chart for research purposes. (NOTE: No patient names, addresses, phone numbers, or email addresses are included in the research records.)

I have read and understand the above information and give my permission to begin a program of Ayurvedic health care with an Ayurvedic Specialist of the Houston Yoga & Ayurveda Ashram.

Participant's Signature: _____Date: _____

HOUSTON YOGA & AYURVEDA ASHRAM INC.
CONFIDENTIAL PATIENT HISTORY

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 Houston Yoga & Ayurveda Ashram 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 by a specialist who 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 specialist 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.

Participant's Signature:_____Date: _____

FOR SPECIALIST USE ONLY:

Specialist Name: _____		Initial Appointment: _____
IO Date: _____	CM Date: _____	ROF Date: _____

(1) PAST MEDICAL HISTORY

*Include major conditions **and** dates of treatment and procedures performed.*

a. Serious illnesses: _____

b. Hospitalizations: _____

c. Operations: _____

d. List other pertinent past conditions: _____

e. Have you been under the care of a licensed health care professional in the past year? ☐ Yes ☐ No

If so, for what reasons: _____

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

If so, please list with dates: _____

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(2) FAMILY HISTORY Indicate immediate family members who have had these conditions. (Go back one generation)

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

(3) ALCOHOL, TOBACCO AND SUBSTANCE USE **PRACTITIONER NOTES:**

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

(4) REGULAR PRACTICES

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

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(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 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 / past eating patterns or food related issues.*

(9) DAILY SCHEDULE *(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 / INTERN NOTES
Morning	Awaken _____	_____
	Mealtime _____	_____
	Activities _____	_____
Day	Mealtime _____	_____
	Activities _____	_____
Night	Mealtime _____	_____
	Activities _____	_____
	Bed-time _____	_____

(10) ALLERGIES OR SENSITIVITIES *List all allergic reactions: (including food, pollens, and medicines)?*

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(11) CHALLENGING PATTERNS *Please indicate any physical and emotional patterns that you find challenging by assigning a value to the* ***Frequency*** *(1-3) and* ***Intensity*** *(1-10) columns of the corresponding issue:*

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

A. DIGESTION

	Frequency 1-3	Intensity 1-10
Excessive gas	(#)	(#)
Excessive belching	(#)	(#)
Acid reflux	(#)	(#)
Burning indigestion	(#)	(#)
Nausea or vomiting	(#)	(#)
Sleepy after eating	(#)	(#)
Heaviness after eating	(#)	(#)
Bloated after eating	(#)	(#)

B. ELIMINATION

	Frequency 1-3	Intensity 1-10
Constipation: less than 1 bowel movement per day	(#)	(#)
Alternating constipation & diarrhea	(#)	(#)
Food particles in stool	(#)	(#)
Diarrhea	(#)	(#)
Rectal pain or hemorrhoids	(#)	(#)
Blood in stool	(#)	(#)
Mucus in stool	(#)	(#)
Abdominal pain	(#)	(#)

C. EMOTIONS

	Frequency 1-3	Intensity 1-10
Worry	(#)	(#)
Anxiety	(#)	(#)
Overwhelm	(#)	(#)
Self-destructiveness	(#)	(#)
Anger	(#)	(#)
Resentment	(#)	(#)
Critical/Blaming	(#)	(#)
Intense	(#)	(#)
Lethargic	(#)	(#)
Melancholy	(#)	(#)
Depression	(#)	(#)
Stubbornness	(#)	(#)

(12) ADDITIONAL SYMPTOMS OF CONCERN	Frequency	Intensity	PRACTITIONER NOTES *Please specify duration and characteristics*
	(#)	(#)	_____
	(#)	(#)	_____
	(#)	(#)	_____

(13) PREVIOUSLY DIAGNOSED CURRENT CONDITIONS	PRACTITIONER NOTES *Please describe symptoms of diagnosed condition*
	_____

(14) AYURVEDIC HISTORY - *For each category, please identify your long-term tendency by placing an "X" in the box that is most appropriate for you. If you are unsure or have questions regarding a specific category, please mark the column with the checkmark (√) to the right.*

CATEGORY				√	PRACTITIONER USE
Appetite	My hunger level is variable, and I often forget to eat. ☐ *Practitioner use only* V☐ P☐	I have a strong appetite and don't like to miss meals. ☐ *Practitioner use only* V☐ P☐	I like to eat, but I can go without eating without any discomfort. ☐ *Practitioner use only* V☐ P☐	☐	____
Appetite	If I miss a meal, I often get light-headed, anxious or cranky. ☐ *Practitioner use only* V☐ P☐	If I miss a meal, I often get irritable or angry. ☐ *Practitioner use only* V☐ P☐	If I miss a meal, it doesn't really bother me. ☐ *Practitioner use only* V☐ P☐	☐	____
Appetite	I prefer to eat frequently with no set schedule, but I often forget to eat. ☐ *Practitioner use only* V☐ P☐	I prefer to eat 3 meals a day at about the same time. I rarely skip meals. ☐ *Practitioner use only* V☐ P☐	I prefer to eat 2 to 3 times daily, but can go without eating. ☐ *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☐	☐	____
Elimination	I tend to have irregular bowel movements one time per day or less. ☐ *Practitioner use only* V☐ P☐	I tend to have 1 to 2 bowel movements daily, usually with regularity 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☐	☐	____
Elimination	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 don't 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☐	☐	____
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: __**

CATEGORY				√	PRACTITIONER USE ONLY
Skin	When I have rashes, they tend to be dry and itchy. Blemishes are usually blackheads. ☐ *Practitioner use only* V☐ P☐	When I have rashes, they tend to be red and burning. Blemishes are usually acne. ☐ *Practitioner use only* V☐ P☐	When I have rashes, they tend to be wet and oozing. Blemishes are usually white pimples. ☐ *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☐	☐	____
MENTAL & EMOTIONAL PATTERNS					
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 decisions easily, but can change my mind with new information. ☐ *Practitioner use only* V☐ P☐	I am careful but easy-going about decisions. ☐ *Practitioner use only* V☐ P☐	☐	____
Projects	I like to start projects, but at times have difficulty 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☐	☐	____
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 ___ day(s) and lasts ___ day(s). ☐ *Practitioner use only* V☐ P☐	My menstrual cycle is regular. It comes every ___ day(s), and lasts ___ day(s). ☐ *Practitioner use only* V☐ P☐					
My menstrual flow is often light, but may vary. ☐ *Practitioner use only* V☐ P☐	My menstrual flow is medium heavy, and is usually consistent. ☐ *Practitioner use only* V☐ P☐	My menstrual flow is heavy and is very consistent. ☐ *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: __	**P VIKRUTI: __**	**K VIKRUTI: __**

(15) CURRENT MEDICATIONS, HERBS OR 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 or Prescription*	*Herb/Drug/ Vitamin?*	*Prescribed by? (Self, MD, Other)*	*For what purpose?*	*For how long?*	*What dosage?*	*What have the benefits been?*
_____	Select	Select	Select	_____	_____	_____	_____
_____	Select	Select	Select	_____	_____	_____	_____
_____	Select	Select	Select	_____	_____	_____	_____
_____	Select	Select	Select	_____	_____	_____	_____
_____	Select	Select	Select	_____	_____	_____	_____
_____	Select	Select	Select	_____	_____	_____	_____
_____	Select	Select	Select	_____	_____	_____	_____
_____	Select	Select	Select	_____	_____	_____	_____
_____	Select	Select	Select	_____	_____	_____	_____
_____	Select	Select	Select	_____	_____	_____	_____
_____	Select	Select	Select	_____	_____	_____	_____
_____	Select	Select	Select	_____	_____	_____	_____