(818)-564-1200

Ayurveda By Kailas

www.ayurvedabykailas. com

# Client Intake Form

**Personal Information**

Name: ______________________________________________ Date: _______________

Address: ___________________________________________________________________

City: ____________________________________ State: _______ Zip: ________________

Phone Number: _________________________ Date of Birth: __________________

Email: ________________________________ Recommended By: _____________________

Reason for Consultation: ______________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

**Current Condition**

What are your symptoms?  Please list as many as possible.

#1: ____________________________________________________________

How Long? ____________

#2: ____________________________________________________________

How Long? ____________

#3: ____________________________________________________________

How Long? ____________

#4: ____________________________________________________________

How Long? ____________

#5: ____________________________________________________________

How Long? ____________

#6: ____________________________________________________________

How Long? ____________

#7: ____________________________________________________________

How Long? ____________

Name and phone of primary care physician: ________________________________________________________

Are you under treatment for this condition? __________ If so, how long? ___________

What does your physician say about your condition? __________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

What major illnesses or operations have you had in your life?

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Have you had a medical exam in the past year? _________ Are there any significant results of the exam?

________________________________________________________________________________________

Are you on any medications? ___No ___Yes

If so, which ones: _________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Are you on any herbal supplements or vitamins? ___No ___Yes

If so, which ones: _________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Do you have children? ___No ___Yes

Have you consistently experienced any of the following:

☐ Abdominal Pain ☐ Allergies ☐ Arthritis ☐ Asthma (childhood) ☐ Asthma – (adult onset)

☐ Blurry Vision ☐ Circulatory Problems ☐ Constipation ☐ Diarrhea ☐ Digestive Problems

☐ Flatulence ☐ Bloating ☐ Headaches ☐ Fatigue / Exhaustion ☐ High / Low Blood Pressure

☐ Low Blood Pressure ☐ Insomnia ☐ Menstrual Irregularity ☐ Migraines ☐ Miscarriage

☐ Ectopic Pregnancy ☐ PMS Symptoms ☐ Respiratory Problems ☐ Congestion ☐ Dryness

☐ Phlegm ☐ Sinus Infections ☐ Skin Problems ☐ Incontinence ☐ Low Back Pain ☐ Strange Pains ☐ Swelling ☐ Stomach Ulcers ☐ Varicose Veins ☐ Nausea

**General Health Information**

Do you have a healthy diet:

☐ Always ☐ Most of the time ☐ Sometimes ☐ Never

What foods do you hate?

_______________________________________________________________________________

_______________________________________________________________________________

What foods do you crave?

_______________________________________________________________________________

_______________________________________________________________________________

Do you exercise:

☐ Once per day ☐ Once per week ☐ More than 1 x week ☐ Seldom ☐ Never

What types of exercise: ______________________________________________________________________

**Family History**

Illnesses from your Father's side of family: _____________________________________________________

Illnesses from your Mother's side of family: ____________________________________________________

**Additional Information You Want To Include**

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________