Ayurvedic Intake Questionnaire

Section I. Student Information and Areas of Interest

Ayurveda places a significant emphasis on understanding the individual and their distinctive needs and interests. To better understand these needs and interests, Ayurvedic counselors often request information about the individual through questionnaires and discussion to help customize the education offered. In order to begin this process of a personalized Ayurvedic education, please provide the following information about yourself:

Name: _____

Email: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Age: _____ Date of birth: _____ Place of birth (State): _____

Height: _____ Current Weight: _____ Adult Weight Range: _____

Gender Identity and Preferred Pronouns: _____

Occupation_____

Relationship Status (e.g. Married, Single, Committed, etc.): _____

Do you have children? _____

Are you currently under the **care of a physician** or **other health professional**?
☐ Yes ☐ No If yes, please share for what (if you are comfortable with it).

_____

_____

_____

Any prior surgeries or hospitalizations?

☐ Yes ☐ No If yes, please elaborate on timing and for what it was for.

_____

_____

Why are you interested in an Ayurvedic consultation?

_____

_____

_____

_____

Please describe your primary health and wellness concerns or areas of interest:

1. _____

2. _____

3. _____

4. _____

5. _____

Are you interested in learning an Ayurvedic perspective on any particular health circumstance?

☐ Yes ☐ No If yes, please name the condition and describe your interest:

1. _____

2. _____

3. _____

4. _____

Section II. Student Medical and Family History

Do you have a personal history or family history of the following:

Symptom (Me/Family)	Me	Fam	Symptom (Me/Family)	Me	Fam
Allergies to Food/Drugs/Mold			Heart Murmur, Palpitations		
Anemia			Hepatitis A / B / Other		
Arthritis			HIV Exposure		
Asthma, Pneumonia, TB			IBS, Colitis, Crohn's, Celiac, etc.		
Autoimmune Disease			Implant, Prosthesis		
Blood Pressure (High/Low)			Kidney or Bladder Disease / Infection		
Cancer / Chemotherapy / Radiation			Mononucleosis, Jaundice, Gallstone		
Chest Pain/Angina			Pain/Ringing in the Ear		
Cholesterol / Triglycerides (High)			Parasites / Tropical / Chronic Infection		
Contact Lenses / Prescription Glasses			Popping, Clicking, Locking of the Jaw		
Dental Treatment Complications			Prolonged Bleeding When Cut		
Diabetes			Psychiatric Treatment		
Dizziness, Fainting			Rheumatic / High Fever		
Epilepsy, Convulsions, Seizures			Shortness of Breath		
Feet or Ankles, Swelling			Stroke. Cerebro-Vascular Accident		
Glaucoma, Eye Surgery			Thyroid Disease or Medication		
Headaches/Migraines			Ulcers, Intestinal Bleeding		
Heart Attack / Disease / Surgery			Venereal Diseases		

If you answered yes to any of the above, can you please add a bit of detail?

_____

_____

_____

_____

_____

_____

_____

_____

Are you interested in learning an Ayurvedic perspective on any particular herbs or supplements?

☐ Yes ☐ No If yes, please list areas of interest:

1. _____

2. _____

3. _____

4. _____

5. _____

Are you taking any medications, herbs or supplements?

☐ Yes ☐ No If yes, please list the name, dosage, how long you've been taking it (them), and for what purpose:

1. _____

2. _____

3. _____

4. _____

5. _____

Do you have any allergies to any medications, herbs or supplements?

☐ Yes ☐ No If yes, please list the name and reaction.

1. _____

2. _____

3. _____

4. _____

Section III. Daily Routine (Dinacharya)

Reviewing and evaluating the daily routines of an individual and how these routines may help or hinder well-being is important information for dialogue about Ayurvedic philosophy. If you would like to learn an Ayurvedic perspective on your daily routine and lifestyle, please answer the following questions as how they are in general for you:

a. Sleep Patterns

Time you wake up (weekdays/weekends): _____/_____

Time you go to bed (weekdays/weekends): _____/_____

How do you generally feel when you wake up in the morning?

☐ Rested	☐ Tired	☐ Angry	☐ Sluggish
☐ Congested	☐ Puffy	☐ Sad	☐ Anxious

How would you describe the quality of your sleep?

☐ Good and regular	☐ Too little	☐ Light, wake often
☐ Difficulty falling asleep	☐ Difficulty waking up	☐ Wake too early
☐ Frequent nightmares	☐ Hot flashes or night sweats	☐ Restless

b. Exercise Patterns

How often do you exercise?

☐ Once weekly ☐ 2-4x/week ☐ Almost daily ☐ Rarely

Exercise intensity:

☐ Vigorous ☐ Moderate ☐ Light or Gentle

Exercise duration:

☐ Less 30 minutes ☐ 30-60 minutes ☐ Greater than an hour

What type of exercise? _____

Do you practice any yoga techniques?

☐ Yes ☐ No If yes, what type and how often?_____

Do you practice any type of pranayama?

☐ Yes ☐ No If yes, what type and how often?_____

Do you practice any type of meditation?

☐ Yes ☐ No If yes, what type and how often?_____

c. Travel Patterns

Do you travel a lot?

☐ Yes ☐ No If yes, please describe (ex: long daily commute, work travel domestic, lots of international travel for pleasure, etc.):_____

_____

Are you stressed by travel? ☐ Yes ☐ No If yes, how so?_____

_____

Do you experience digestion issues when traveling? ☐ Yes ☐ No If yes, how so?

_____

d. Eating Patterns

Do you eat your meals at regular/consistent times? ☐ Yes ☐ No

Which is your main meal of the day? ☐ Breakfast ☐ Lunch ☐ Dinner

Rate your digestion: ☐ Good ☐ Fair ☐ Poor ☐ Unsure

Do you experience gas, bloating or heartburn? ☐ Yes ☐ No

If yes, which one, how often, and do you recognize a trigger?

_____

How much water do you drink daily?

☐ None ☐ 1-2 glasses ☐ 3-4 glasses ☐ 5-6 glasses ☐ 7+ glasses

- Water temperature: ☐ cold/iced ☐ room temp ☐ warm

What else do you drink during the day? How much? Caffeine?

_____

Please describe your typical food habits including time, surrounding environment (ex: electronic devices, driving, working etc) and typical foods:

Breakfast_____

_____

_____

Lunch _____

_____

_____

Dinner _____

_____

_____

Snack _____

_____

Special diet? ☐ Vegan (no animal products) ☐ Lacto-vegetarian (dairy, no eggs or meat)
☐ Ova-lacto-vegetarian (dairy & eggs, no meat) ☐ Other

Please describe if "other": _____

Are there any particular foods that create discomfort when you eat them? Check all that apply.

☐ Sweet ☐ Salty ☐ Fried ☐ Meat ☐ Gluten ☐ Dairy products
☐ Sugar ☐ Beans ☐ Spicy

Do you avoid any foods to feel good/better? If so, please describe:_____

_____

How much alcohol do you drink?

☐ None ☐ 1 a day ☐ 1+ day ☐ 1 a week ☐ 1+ week ☐ Monthly

- Type: ☐ Wine ☐ Beer ☐ Other

My eating habits include (check all that apply):

☐ Eat with full attention on food ☐ Talk or converse while eating ☐ Eat very fast
☐ Watch television while eating ☐ Eat while driving or working ☐ Never sit to eat
☐ Frequently skip meals ☐ Take out often ☐ Rarely cook

How often do you eat the following:

Food	Never	Daily	Weekly	Monthly
Grains				
Vegetables				
Fruit				
Dairy				
Eggs				
Poultry				
Meat				
Seafood				
Dessert				

What type of foods do you crave?

☐ Sweet ☐ Salty ☐ Fried ☐ Spicy ☐ Sour ☐ Cold ☐ Hot

How is your appetite? ☐ Weak ☐ Strong ☐ Variable

e. Elimination

Describe your bowel movements:

☐ Once daily
☐ Every other day
☐ First thing in the morning
☐ After morning coffee
☐ Once every 2-3 days
☐ Every 2-3 days
☐ Late in the daytime
☐ Need laxative daily
☐ 2-3 times per day
☐ 2-3 times per week
☐ Immediately after meals
☐ Other, please specify:

Please explain:_____

Bowel texture: ☐ Soft, formed ☐ Liquid ☐ Hard or dry ☐ Combination

Please explain: _____

Bowel movement associated with:

☐ Pain ☐ Gas ☐ Blood ☐ Mucus ☐ Foul smell ☐ Straining

Sweat: ☐ Scanty ☐ Moderate ☐ Profuse ☐ Variable

Please explain: _____

Urination (check all that apply):

☐ Frequent during the day
☐ Clear
☐ Brown
☐ Painful or burning
☐ UTIs
☐ Frequent at night
☐ Pale yellow
☐ Cloudy
☐ Difficult
☐ Kidney stones
☐ Rarely
☐ Bright yellow
☐ Bubbles
☐ Feels incomplete

Please explain: _____

How consistent is your daily routine? (For example, do you go to bed at a consistent time, eat your meals at consistent times, work consistent hours, exercise r consistently?)

☐ Very regular ☐ Somewhat regular ☐ Irregular (often changing)

Do you oil massage daily?

☐ Yes ☐ No If yes, what type of oil do you use? _____

How would you rate your usual energy level?

☐ Very high ☐ High ☐ Moderate ☐ Low ☐ Very low

Do you often experience any of the following? Check all that apply.

☐ High stress level	☐ Worry	☐ Anxiety	☐ Fear or panic
☐ Loneliness	☐ Depression	☐ Memory loss	☐ Light-headedness
☐ Lack of energy	☐ Anger	☐ Irritation	☐ Lethargy

Do you smoke cigarettes or vape? ☐ Yes ☐ No

If yes, how much per day? ☐ 1-4 ☐ 5-10 ☐ 10 or more

Section IV. General Lifestyle

a. Social Lifestyle

How is your career?	☐ Love it	☐ Like it	☐ Tolerate it	☐ Dislike it
How is your social life?	☐ Excellent	☐ Good	☐ Fair	☐ Poor
How are your family relationships?	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Rate your spiritual life:	☐ Empty	☐ Neutral	☐ Satisfying	☐ Strong

b. Goals/Achievements

How would you rate your memory? Check all that apply.
☐ Quick to learn ☐ Quick to forget ☐ Long term ☐ Short term

How are you with achieving goals? Check all that apply.
☐ Scattered ☐ Focused ☐ Determined ☐ Lack of goals

How would you rate your concentration? Check all that apply.
☐ Scattered ☐ Focused ☐ Strong ☐ Weak

c. Sexual and Reproductive Lifestyle

What method of birth control do you use? _____

Are you pregnant now? ☐ Yes ☐ No ☐ Not sure ☐ N/A

Pregnant in the past? ☐ Yes ☐ No ☐ N/A

If yes, describe any complications or method of birth:_____

_____

Which of the following describes your menstruation?
☐ Regular ☐ Irregular ☐ Too frequent ☐ Absent ☐ Ceased/menopause ☐ N/A

How many days does your menstrual period last?
☐ 0-4 days ☐ 5-7 days ☐ More than 7 ☐ Spotty ☐ N/A

How is your menstrual flow? ☐ Light ☐ Normal ☐ Heavy ☐ Abnormal ☐ N/A

Associated symptoms (before or during menstruation):
☐ Cramps ☐ Fluid retention ☐ Breast tenderness ☐ Migraines ☐ Frustration
☐ Acne ☐ Depression ☐ Back pain ☐ Nightmares ☐ Loneliness

Are you experiencing any symptoms of menopause? Check all that apply.
☐ Hot flashes ☐ Insomnia ☐ Memory Loss ☐ Mood swings ☐ Vaginal dryness

Do you have any sexual or reproductive concerns or difficulties?
☐ Yes ☐ No If yes, please explain:

_____

d. Other Lifestyle Areas of Inquiry

What additional areas of inquiry would be served by an Ayurvedic perspective, if any?

1. _____

2. _____

3. _____

e. How do you de-stress?

_____

_____

_____

_____

f. Please share anything important that was not covered.

_____

_____

_____

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_____

_____

Section V. Educational Agreement (Required)

I _____ agree to all of the above and confirm my understanding that this consult is an educational experience for the purpose of learning Ayurvedic perspectives on health and wellness. I understand this educational consult does not include medical diagnosis or medical treatment and is not a substitute for medical care. You are encouraged to discuss any Ayurvedic concepts that are of interest to you with your primary health-care physician. This consultation does not take the place of your qualified health care practitioner(s) and should in no way be considered as a substitute for their care. Continue to take any prescription medications and follow any recommendations from your physician.

_____
Print Full Name

_____
Signature

_____
Date